Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
amen #9,10g,11,12,15,&16a&b Per ANA BD G923 1/18/2012 Jh
State of Maryland / Department of Health and Mental Hygiene
Amend Item 24a per verb.,g923.01/12/2012dhb
Certificate of Death
Reg. No. 2 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29 2011 DECEMBER Physician/ 37 BONIFACIO ROMERO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Yea
March 14, 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1941 1 XM 2 - F **Director** 70 640-24-6682 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 No Hyattsville Prince Georges MD 10g. Citizen of What Country? 10e, Street and Number Zip Code 20783 Funeral 1407 Kanawha St; Apt 202 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent Ever in U.S. Armed Forces? **unk** 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status unk Black, White, etc. þ 1X Never Married 2 Married Specify: hispanic Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates. 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construction unk 0 unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk ပ္ Andres Romero Dominia Romero 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1407 Kanawha St; Apt 202; Hyattsville, MD 20783 Maura Suentes - friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Signature of Euneral S. ROna 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CEMIA Physician/ 5EPTI Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death ed by the a detached f 4 L Pregnam 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ REMAL DISEASE END STAGE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? OSTRIONUM DIFFICILE 24a. Was an ate has page 2 s autopsy performed?

1 Yes 2 X No COLITI 1 Yes 2 No ISCHEMIC 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending of Funeral Director; After death.

e Funeral Director; After detely filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Saul D00 6905 MU DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 TAKOMA PARK, MD. 20912 WIREDU AID OD 3. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #1 Per FH C923 1/12/2012 JH

Per FH C923 1/12/2012 JH

Continues of Death

Continues of Death For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Christine Sanders Physician/ 3: 20 AM ANDERS DEC 0 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Columbia Howard **Howard County General Hospital** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Min. (Month, Day, Year) Dec 28, 2011 MD n/a Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10a, State 10c. City. Town or Location the Maryland Director Examiner must be notified Windsor Mill MD **Baltimore** 1 🗌 Yes 2 🕱 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21244 U.S.A. 2811 Greshem Way items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Marital Status Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event the Man College (1-4 or 5+) Elementary/Seconday (0-12) infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Titilayo L. Oilwo **David Sanders** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2811 Greshem Way Windsor Mill, MD 21244 **David Sanders** father 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Columbia Memorial Park Burial 2 Cremation 3 Removal from State Jan 04, 2012 Clarksville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 of Funeral Service License Part 1. Enter the claese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final ∙ Ph_sician/ EXTREME 9110ul IREMATURITY disease or condition resulting in death) Medical Examiner HPIRATORY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oil) INGUMO THORACU attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Day signed by the a Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown Division of Vital Records, Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has page death? 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work?
1 \(\sum \) Yes 2 \(\sum \) No injury Natural 5 Pending in 24 hours arter the Funeral Director: Aft Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title DEC 2 mb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWARD COUNTY GENGER HUSPITM GARY BLECHMAN M-0 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Day 630PM **GREGORY SMALLWOOD** 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Lanham Doctors Hospital 8. Date of Birth (Month, Day, Ye Dec. 26, Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Days Hours Min. 1 🛛 M 2 🗆 F **Director** 55 577-76-6204 Dec. DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2X No Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20720 USA 4200 Day Lilly Dr. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 1982 Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black 3 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) 2 yrs. Elementary/Seconday (0-12) Train Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental I item 27 is marked o ٩ Page 1 and 2 should be Hubert Smallwood Mary Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillie M. Smallwood - Wife Bowie, MD 20720 4200 Day Lilly Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o once. o X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National 1-6-2012 Suitland, MD Signature of Juneral Service Licenses Marshalld Marchity Funeral Home of Maryland Suitland, MD 20746 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) Huerosc Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No for Day Month Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ٥ 1 🗌 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending injury Accident Investigation 1 Yes 2 No 24 hours after deatl Funeral Director: filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD LICK 31. Date filed (M 2. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43004 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 24 Physician/ Smith Carmen 2011 9:25 A M Maria Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Wicomico 8925 Executive Club Dr. Delmar 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 02/15/1933 1 ☐ M 2X F 78 **Director** 577-56-5345 Usual Residence of Decedent "natural", or items 23a or 28a-f shov idical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County the Maryland 10c. City. Town or Location Director MD 1 Yes 2 XNo Delmar Wicomico 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral United States 21875 8925 Executive Club Dr. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black White etc. þ 1 Never Married 2 Married filed within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other threamy injury or other traumatic event the once. other traumatic event, the Own Home Homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Blanco Gallego Maria Marciano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas G. Smith / Son 5415 Galley Ct., Fairfax, VA 22032 Baltimore, 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 01/05/2012 Beltsville, MD Name and Address of Facility
Rapp Funeral and Cremation Services Gist Ave., Silver Spring, 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final - Ph_{sician/} disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Year Month Day Pregnant at time of death 5 Other (specify) 1 | Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has perform death? 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မြ Manner of Math 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury (Month, Day, Year) work? To the Hospital within 24 hours after death.

To the Funeral Director: Aft Natural 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. Licens 29d. Date signed (Month, Day, Year) Signature 14 30. Name and address of person who completed cause of death (Item 23a) [Type, Print)

DHMH 17 Rev 7/2009

State Registrar filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201 erman December Medical Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death Stown Homore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) If Under **Funeral** Min. **Director** 1 №M 2 🗆 F \subset Usual Residence of Decedent 28a-f shov death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Yes 2 No timore 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked any injury or other. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates. 2 No 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MINHERANLO inaa Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NIC rman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 D Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility 22 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as dardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner 1111815 Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last the attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy should be detached for in the past 12 months? Day 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown been signed by Part // Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 200 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury __ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed Month, Day, Year)

State Registrar DHMH 17 Rev 06-2011 SMITH AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stern Mary Margaret 08:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Overlea Health and Rehabilitation Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) Months 190-14-1367 Director 1 🗆 M 2 💢 F 90 PA 01/01/1921 "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21214 3020 Glenmore Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force
1 Yes 2 Black, White, etc. 1 Never Married 2 Married þ 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Law Office Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Malanowski Stanley Yohas other traumatic Mary 1 and 2 should be of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Norma Tucky - Cousin 5407 Forest Avenue Parma, 0H 44129 Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland Hilltop Svc. Corp. 1/6/2012 Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Depardua 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebehonouse disease or condition Medical resulting in death) Examiner Atherosile Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ched for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 6 ballation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an multi- intarit performed? Hyperters, Director: After this certificate 1 Yes 2 No 25. Was case re r d to medical Be 26. Place of Death (Check only one) examiner? Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 80 D00 70827 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MMAHOM WATINS ST # 308 Baltmare MD 21201

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12-28-2011 Evert Franklin Woods 0215 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's County Hospital Cheverly Prince George's Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Hours 186-32-3695 Director 1**X** M 2 □ F 72 05-10-1939 PA Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1

Yes 2 □ No MD Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3819 Dent Street 20743 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by Black, White, etc 1 Never Married 2 X Married 1 v Yes 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates. 1957–1961 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Plumber** 12th Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul Vincent Woods Mildred Gertrude Edmiston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Woods/wife 3819 Dent St., Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 □yBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 01-11-2012 Cheltenham, Maryland eral Service Licensee 21. Signature of W 22. Name and Address of Facility Cedar Hill Funeral Home, 4111 PA Ave., Suitland, MD 20746 23a. Part 1. Enter the disease. complications that caused shock, or heart failure. List only one cause on each line ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATAL *eisu*c disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to (or as a cur sequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Vear Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 💢 No 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation **Director:** 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b. Signature and tit 29d. Date signed (Month, Day, Year) 30. Name and address of person who com cause of death (Item 23a) (Type, Print) GRIFFIN HOSPITAL DAVIS 3001 State r's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 430	0	
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		1- For State Registrar	•	ate of Death	vicitairiyg	Reg.	No.	
Physici Modical Exam		Decedent's Name (First, Middle,Last) December Transport Tr				Date of Death Month D	ay Year	3. Time of Death 1136 hrs
	mei	Donna France 4a. Facility Name (if not institution, give street and number)		Zientak 4b. City, Town, or Loca		December 2	8, 2011 4c. County of I	
		Johns Hopkins Hospital		Baltimore			io. county of	304.11
Funeral			e (In yrs. last birth	**	f Under 24Hrs. 8 Hours Min.	. Date of Birth (9. Birthplace (State or oreign
Director		218-86-0276 1_M 2XF	50	Yrs.	Tiours Iviiri.	May 18,		Country) Maryland
Any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town of	or Location				10d. Inside City Limits
E .	F	Maryland N/A	Balt	imore				1 X Yes 2 No
Maryland 28a-f show datonce.	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What	Country?
eath with the Maryland items 23a or 28a-f sho ast be notified at once		267 S. Ellwood Avenue		212	24		USA	
ath will terms (Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		 Was Decedent of Hispani If Yes, specify Cuban, Me 			14. Race - A White, e	American Indian, Black, etc.
fter de l", or		3 Widowed 4 Divorced If Yes, Give Year	ΧNο	1 Yes 2 X No sp	ecify:		Specify: W	hite
nours a	ed by	15. Decedent's Education (Specify only highest grade com		ecedent's Usual Decupation (uring most of working life, DO		done 16	b. Kind of Busin	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examine	Completed	Elementary/Secondary (0-12) College (1-4 or 9 12 years	5+)			Cl ords	ma la sala s	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica	E O	17. Father's Name (First, Middle, Last)		Marketing Depa	fother's Name (Fir			ne company
Should be filed vand Mental Hyginarked oth	Be	James John Tagliaferro Sr.			Theresa	Catheri	ne Conn	or
should not Me mis ma	70	19a. Informant's Name/Relationship (Type, Print) Elizabeth J. Repko sist		Mailing Address (Street and				
ore, MD ss I and 2 sho of Health and of Health and if item 27 is her traumati		20a. Method of Disposition		O Millwright (ry Da	ate 20		and 21009 ity or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahe injury or other traumatic event, the Medical Examiner must be notified at once		1 X Bunal 2 Cremation 3 Removal from Sta	te cremato	ry or other place) Heart of Jesus Cer	Janua	ary		Maryland
altin mit. P. sartmes portan		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	1.1	22. Name and Address of F Connelly Fund				-
E E E E	. 9	arthous Conne	elly	1/110 Sollers	Point R	oad. Du	ndalk.M	D. 21222
Physician /Medical		23a. Fart I. Enter the disease, a mplications that caused failure. List only one cause on each line.	the death. Mnot	enter the mode of dying, such	n as cardiac or res	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Mixed Drug	g Intoxi	cation(Phency	clidine,	Oxycod	one, Fe	nt any 1 Death
		Sequentially list conditions, b						
	Examiner	if any, leading to immediate Due to (or as a consecute Cause. Enter Underlying Cause	quence of):					
F. S. A.	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a conse	quence of):					
'60, at be executed bhysician and the burial - transit		d. ▼ UNPENDED AMENDED 23a	ant II.	27,28a-f per п	ne a92/1 1	2_2_12_1		
760, cate be ex physician he burial-	Medical	IF FEMALE: 23c. If yes, outcome			IC 6724 2		23d. Date of de	livery
	ian/	23b. Was decedent pregnant in the past 12 months?	2		ctopic pregnancy		Month	Day Year
Records, P.O. Box 687 The law requires that the death certific care has been signed by the attending page 2 should be detached for use as the control of the	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown	time or death 5	Other (Specify)				
P.O. I s that the gned by the		Part II. Other significant conditions contributing to death	but not resulting	in the underlying cause given	in Part I.			te to the cause of death?
S, P.(uires that n signed Id be deta	ed by	Cocaine Use						Probably 4 🗹 Unknown
of Vital Records, ig Physician: The law requirement. The taw requirements certificate has been as neral director, page 2 should be	Completed					24a. Was an autopsy performed	prior	re autopsy findings available r to completion of cause of
tal Rec	5					1 ✓ Yes 2	d? dea No 1 ✓	Yes 2 No
/ital sician is certi	B	25. Was case referred to medical examiner? Hospital: Inpution	nt 2 🗸 ER/Out	- LOtha	eath (Check only		idence 6 (Other
ion of Vital literating Physician: eath. or: After this certifithe funeral director,	일	1 ✓ Yes 2 No I inpatier 27. Manner of Death 28a. Date of Injur (Month, Day, Ye	v 28b. Ti	me of Injury 28c. Injury at		. Describe how		
ion of trending Pt leath. tor: After tree funeral	atio	Natural 5 Pending	8-11 fd	1030hrs 1 Yes	2 X No u	nknown		
Division pital or Attendir ours after death. reral Director: A	Certification:	3 Suicide 6 X Could not be 28e. Place of Inju		n, street, factory, office building		or Town, State	267 S.	Rural Route Number, City Ellwood Ave.
Iospita 4 hours 7 unera		4 Homicide 29a. Certifier	sidence	a accurred at the time, date or		altimor	e, Md.	
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: , completely filled in by the fi	Medical	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated.						
H 3 F 8	Me	29b. Signature and title of certifier	1	29c. License nur		29	d. Date signed	(Month, Day, Year)
		Celus 1	7	7 O.C.M.E.		D	ecember 29	, 2011
0		30. Name and address of person who completed cause of de Zabiullah Ali, M.D. Assistant Medical Ex		W. Baltimpre Street, E	Baltimore MC	21223		
St	ate	31. Date filed (Month, Day Year) 32. Registrar 33. Date filed (Month, Day Year)	s Signatuse					
Regist	rar	JAN I U 2012 Conque &	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SRA 011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death HOUSE OCKVILL MONTGOMER Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min Director 1 M 2 F 11 AKISTAN 28a-f show at 10c. City, Town or Location Director notified MD MONTGOMERY GAITHERSBURG 1 Yes 2 No 10e. Street and Number r items 23a or ner must be n ò 10g. Citizen of What Country? Funeral 208 330 SA AMERICAN "natural", or iten edical Examiner r 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 No Maryland 21215-0036 Specify: ASIAN 1 Yes 2 No Specify: 3 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the RESEARCH HEALTH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ K. BHATTY NASIRA alth and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 57% SHABBIR AMERICAN WAY GAITHERSBURG MD HUSBAND 330 permit. Page 1 and 2 Department of Healt Important; If item 2 any injury or other 1 Baltimore, Place of Disposition (Ivaline cometery, crematory or other placemetery, crematory or other placemetery) 20a. Method of Disposition 20b. Place of Disposition (Name of 1

Burial 2 ☐ Cremation 3 ☐ Removal from State 12/30/11 FREDERICK MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER WOODBRIDGE 23a. Part 1. Eper the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause of a ch line. Interval Between Onset and Death Immediate Cause (Final Physician/ Varian disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 the as IF FFMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ ō in the past 12 months? Pregnant at time of death Month Day Year 2 No Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? S Q Hospital or Attending Physician: The law requires Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 🗷 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ျှ 1 🗌 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) 📙 🗸 🕻 🗲 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending s after death. Accident Investigation the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the F 29d. Date signed (Month, Day, Year) R 120698 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTENSON CRNP 1355 PICCARD DR. STE. 100 ROCKVILLE MD. 20850 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Physician/ December Day 17,2011 Bullock 11:50 M Clarence Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year I If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Director 245-42-2670 1 **X** M 2 □ F 78 June 29,1933 NC Usual Residence of Decedent 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Ħ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD PG Temple Hills 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 4007 28th Avenue 20748 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give 1951 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or ite Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: Specify:Black Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) r than " Elementary/Secondary (0-12) College (1-4 or 5+) Fork Lift Operator Giant Food Warehouse Be 17. Father's Name (First, Middle, Last) ant of Health and Mental Hit: If item 27 is marked out y or other traumatic even 18. Mother's Name (First, Middle, Maiden Sumame) မ Leslie Bullock Sr Hattie Cofield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4007, 28th Avenue
Temple Hills, MD, 20748 Joanne Bullock/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Department c Important: If any injury or once. Veterans Cemeter

Veterans Cemeter /29/11 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 21. Sign Ture f Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD.20746 23a. Part/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Myseadel disease or condition resulting in death) Indacton Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): burial-transit Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) ng physician a as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation To the Funeral Director.. completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 00068207

CR-4+1

State Registrar

DHMH 17 Rev 06-2011

Olinton mod

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100,

9 2011

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 25 2011 December

for State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2:20 P M John K. Boyd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Temple Hills 5921 John Adams Dr. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Min (Month, Day, Year) Director 214-94-1837 Usual Residence of Deced 1 🕱 M 2 🗆 F 45 20 1966 Washington, DC July 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location a with the Maryland Director notified Largo 1 X Yes 2 No Md Prince George's 10e. Street and Numbe 0 10f. Zip Code 10g. Citizen of What Country? must be n Funeral USA 20774 224 Harry S. Truman Dr. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Examiner Black, White, etc. African-0 1 Never Married 2 Married þ within 72 hours after 3altimore, Maryland 21215-0036 nan "natural", Medical Exan If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed American Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Private 12 Maintenance Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edna Farmer John Boyd traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar. Important: If item 27 is any injury or any 224 Harry S. Truman Dr. Largo, Md Shontta Boyd / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Brentwood, Md 1/5/12 Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funer 15 22. Name and Address of Facility Fort Lincon Funeral Home Brentwood, Md lances 3401 Bladensburg Rd 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailue. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Float Ph_sician/ Metastatic Adenocarcinoma disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 as IF FEMALE: ves, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year Pregnant at time of death signed by the at Id be detached fr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Bowel Obstruction Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗆 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other:
4 Nursing Home 5 Residence 6 X Other (Specify Residence 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No Investigation Accident filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 12/27/11 D006H690 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 101A Greenbelt, MD 7500 Hanover Pkwy 32. Registr State DEC 2 9 2011

Registrar DHMH 17 Rev 06-2011

Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 O. Box 68760 Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 22, 2011 P^{M} December 3:55 Constance Helsel Beachy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Garrett Grantsville Goodwill Mennonite Home 8. Date of Birth (Month, Day, Year) Sept. 19, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🔀 F 1938 Pennsylvania 73 Director 214-36-7101 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2X No Director MD Allegany LaVale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō USA items 23a 12214 Henry Dr. 21502 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 XNo 1 Never Married 2 Married ٥ If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: Specify þ White 3 XWidowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, The Magnee. Elementary/Secondary (0-12) College (1-4or 5+) California DMV 12 Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Dando ည Benjamine Hamilton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2519 Symphony Lane, Gambrills, MD 21054 Christopher R. Beachy/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 27, 2011 Bittinger, MD Bittinger Cemetery 22. Name and Address of Facility Newman Funeral Homes, P.A. ama 23a. Part 1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearly failure. List only one cause on each line. P.O. Box 275, Grantsville, MD 21536 Approximate Interval Between Onset and Death Immediate Cause (Final Physician PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner intection-vira Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed advanced Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 22 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an After this certificate has funeral director, page 2 t autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ouldand, MD 3019 highway Margare ma Month, Day, Year)
DEC 28 2011

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Keyon Burnside, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 26, 2011 Medical Examiner 1116 hrs Keyon I. Burnside, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1000A Heather Ridge Drive Frederick Frederick 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country)Maryland Nov.8, 2007 4 220-79-1544 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No Frederick Maryland Frederick hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21702 United States 1000 A Heather Ridge Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican. etc.) Armed Forces? White, etc. 1 X Never Married 2 Married 2 1 No Yes 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Black Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than ", injury or other traumatic event, the Medical I N/A N/A Baltimore, MD 21215-0036 0 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katrina Camphor Keyon I. Burnside, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 A Heather Ridge Drive, Frederick, MD 21702 Keyon Burnside Sr. / Father 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 1/6/2012 Frederick, Maryland 4 Donation 5 Other Specify Stauffer Crematory Stauffer Funeral Home 21. Signature of Funeral Service License 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Part I. Enter the disease, or complicat that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and Medical Death a Developmental Encephalopathy complicated by pneumonia Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical 23a, 27, per me, g924 2-8-12 sm X UNPENDED attending physician or use as the burial AMENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records. 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 Yes 2 No 28c. Injury at Work? After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 X Natural t 24 hours after death.

Funeral Director: A etely filled in by the fu Pending 2 _ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 | | Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal within 2 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22 a v O.C.M.E. December 27, 2011 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State arka Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 55 PM erwag INIa Dec 201 /Medical 4a. Facility Name (# not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner loods bor rederick If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 180-22-33 Months Days 1 □ M 2 🗷 F Director July 14 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at MD Director 1 AYes 2 No edevick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Machine. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 賢No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No 3 ☐ Widowed 4 M Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Governmen ed. 2 17. Father's Name (First, Middle, Last) 18 Mother's Name (Pirst, Middle, Maiden Surname) Be VIIno ဥ 19a. Informant's Name/Relationship (Type. Print) (Street and Number or Rural Route Number, City p Nancy L. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation /5 ☐ Other (Specify) ano 21. Signa ure Hanover PA 17331 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Cluse (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After t completely filled in by the funera 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SOZUIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 hely Wolfe C 31. Date filed (Month, Day, Year) 9.th St. nedench mo 300 W. State 32. Registrar's Signature 22 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28^{ay} Mont 20⁴ 10:00A M Maria Magdalena Chavez Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 7016 Contee Road Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min 05/24/1929 **Director** 1 🗆 M 2 🔀 F none 82 Vrc ElSalvador Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland at Director r 28a-f s notified MD Prince Georges Laurel 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 7016 Contee Road 20707 ElSalvador Was Deces... Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 X Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 1XYes 2□No Specify:Salvadoran Completed SpecifyWhite 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) housewife 4th_grade home maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ဂ္ Rafael Parada Maria Chavez other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important: If item 27 is any injury or other trau once. Jose Hernan Chavez (son) 7016 Contee Rd., Laurel, MD 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Family Cemetery 01/06/2012 El Salvador 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bacon Funeral Home Wanda C. 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ Una disease or condition resulting in death) cancer UNKNOWN Medical Due to (or as a const quence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Lause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ertifier 29b. Signature and title 02500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9200 JAY LIPPMAN MO Basil Date filed (Month, Day State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First, Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month Day 755 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 190-56-0772 **Director** 1 🗶 M 2 🗆 F 38 May 11, 1973 Ohio Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA Dauphin 1 X Yes 2 □ No Harrisburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 804 N. Second Street 17102 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. "natural", or 1 X Never Married 2 Married by Baltimore, Maryland 21215-0036 72 hours after ☐ Yes 1 Yes 2 No Specify: If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Completed White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) rould be filed within 72 Ind Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Marketing Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Cervenak Sharon R. Weeldreyer of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Joseph Cervenak / Father 290 Lynbrook Drive North, York, PA 17402 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 X Removal from State Jan. 4 Donation 5 Other (Specify) White Rose Crematory 2012 York, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. J. Hartenstein Mortuary, Inc. N. Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ -ymphoma disease or condition **Medical** resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to immediate Examine Divide foliar es e consequence of) cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year been signed by the a should be detached f 2 🗌 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? Yes 2 No 1 ☐ Yes 2 ☐ No the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: 1 🗌 Yes မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending (Month, Day, Year) 1 Natural after death. Director: Af 1 🔲 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Coundle & Mount , MD see moer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) armelle Norice 600 MD 31. Date filed (Month, Day, Year) State JAN 1 2 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 30, 2011 Physician/ 23:23P. M Frieda Cohen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Columbia Howard If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 053-22-6801 Days Hours July 18, 1929 Brooklyn, NY Director 1 M 2 XF 82 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Beltsville 1 ☐ Yes 2X No Maryland 10f. Zip Code 10g. Citizen of What Country? ntal Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be n Funeral 4821 Lincoln Avenue 20705 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper Manufacturer permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David Cohen Rose Berstein 19a, Informant's Name/Relationship (Type, Print)

Thomas P. Downs -Attorney 19b, Mailing Address (Street and Number or Rural Route Number, City or Toyn, State, Zio Code) 319 Main Street,#103 Laurel, Maryland 20707 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Mt. Hebron Cemetery 1 X Burial 2 Cremation 3 Removal from State 1/3/2012 Flushings, New York 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Bohald ViesBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ DEGILITY MONTHS - YEARS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** DEMENTIA YENT-S NO STAGE Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of and I-tran that initiated events Due to (or as a consequence of). resulting in death) Last physician a s the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 poinths?

1 Yes 2 No

9 Unknown for t signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEGENERATION , HYPERTENSIEN, MACULAR No 3 ☐ Probably 4 ☐ Unknown OSTED PORUSIS, SIP BREAST CANCER WITH LUMIZETOMY 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other Specific INPACIENT Hospital 1 ☐ Yes 2 XNo After this of funeral dir ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F

Registra

State

29b. Signature and title of certifier

Fahma 972

R. FATIMA A MAQUII

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

20069962

6334 CEPAR LANE, LORION (COLUMBIA) 21044

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0031M OPCOMbe 2011 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death (WOSHINS TON 4b. City, **Examiner** Mesicol ente. 403es90W If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) 208-28-7196 1 🛚 M 2 □ F **Director** Yrs. 74 1937 Greencastle, PA 10 02 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No PA Greencastle Franklin 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be with Funeral 17225 US 241 E. Grant St. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. white Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Truck mfg. assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gladys Irene Bivens Wilber Lee Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 241 E. Grant St. Greencastle, PA Connie L. Cooper Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 01/03/2012 cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Waynesboro, PA Cumberland Valley Crematorium 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Miller-Bowersox Funeral Home 22. Name and Address of Facility Greencastle, PA 17225 521 S. Washington St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Mut. Onset and Death Immediate Cause (Final 10805 Physician/ DIMONUSMO disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) executed burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for g Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Chath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After t Natural 5 Pending injury ours after death.

Ieral Director: Aft
filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOTTON MIC

31. Date filed (Month, Day, Year)

Mer. TUS

Pegistrar's Signature

0005301

2012

Please Type or Print in Black Indelible Ink. Fnsure All Copies Are Legible. Amend 26 per med cert G923 1/12/12 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 31, Physician/ Douglas Allen Dayhoff 2011 December 1:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mount Airy Frederick **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) Months Davs Hours **Director** 215-16-0505 1 XM 2 - F 89 Yrs Oct. 8, 1922 Maryland ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1037 Dulaney Mill Drive 21702 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Completed 3 Divorced Year or Dates. **'42-'46** Specify: White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant **Finance** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilford Ellis Davhoff Margaret Mae Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Allen Dayhoff/Son 1037 Dulaney Mill Drive, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 4. ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cemetery 2012 Frederick, Maryland Keeney and Basford PA Funeral Home, Church Street, Frederick, MD 21701 21. Signature of Juneral Service License 106 East Church Street, Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ 5 disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine cause. Enter Underlying Dure to for sels, consequence on: Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 🗌 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 X Other (Specify) hospice Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred atural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Could not be 24 hours after death Funeral Director. Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. Certifying Physician: Medical Examiner O Certifying Nurse Fra To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continued to the cause(s) and manner as stated. 29a. Certifier 2 [3 [(Check within 2 To the only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2170 - 110 BAUGHMANI lane MD State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43020 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 30, 2011 December 7:05 a.m.M Cecelia Catherine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Chaptico 26375 Budds Creek Road 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours 01/10/1933 Director 212-36-2030 78 Usual Residence of Decedent 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 Tes 2X No Maryland St. Mary's Chaptico and 2 should be filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26375 Budds Creek Road 20621 United States Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married Completed by 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Raymond Goldsborough Catherine Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i P.O.Box 152, Chaptico, MD 20621 Trish Davis/Daughter or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church Cem. 01/04/2012 Chaptico, Maryland 21. Signatur Service Discharge 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Margaret н. Hicks M01631 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani IN FARCTION MYOCAPDIAL 24 /TRS disease or condition Medical resulting in death) Examiner It ZITKIMKRIS Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death ed by the a detached t Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by IAKETES 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) D0014168 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14) Rma

DHMH 17 Rev 7/2009

State Registrar Robert J. Bauer,

M.D.

28103 Three Notch Road, Suite 101, Mechanicsville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43021 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Year Roger Lee Detrick DEC. 19 2011 2:52P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Garrett Co. Memorial Hospital Oakland Garrett Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Months (Month, Day, Year) Days Hours Min. 60 218-62-7240 Maryland **Director** 1951 May Usual Residence of Decedent ms 23a or 28a-f show 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MDGarrett Friendsville 1 XYes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 908 Second Avenue Funeral 21531 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Force Black, White, etc. ō 1 X Never Married 2 Married ş 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural", Specify: white Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Ifth and Mental Hygie 27 is marked other r traumatic event, the <u>Machine operator</u> Manufacturing Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Demetrious M. Detrick Sadie C. Sines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maude A. Rounds/sister f Health airtem 27 i 211 Rocky Mtn. Dr., Grantsville, MD 21536 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Page 1 a 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Country Side Crem Dec 23,2011 DavidsvillePA 22. Name and Address of Facility Newman Funeral Homes, P.A. Signature of Funeral Service Sicensee 179 Miller St Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Physician/ cerebrovascular arcident disease or condition Medical resulting in death) **Examiner** perferring 7R5 Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events YRI burial-transit resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Month cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an auto_k performed 1 Yes 2 No Division of Vital or Attending Physician; filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ER/Outpatient 3 DOA 2 1 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar

State

(Check

only one 29b. Signalu

ONACK 31. Date filed (Monta ho completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

1027

richter MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30035

MEMORIAC DRIVE OAKLAND MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State of Maryland / Department of the Port of	rtificate of Death	Reg. No.	3022				
1	Physici		Decedent's Name (First, Middle, Last) ELOUISE HART EDMONDS		Month Day Voor	Time of Death				
	/Medic Examin		4e. Fecility Name (If not institution, give street and number) 704 LARCHMONT AVENUE	4b. City, Town, or Location of Deeth CAPITOL HEIGHTS	4c. County of Deeth PRINCE GEORGE	S				
	Funeral Director		5. Social Security Number 227-42-1630 6. Sex 1 M 2X F 7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Year) 9. Birthplace (Country) une 13, 1936 Glouces	State or Foreign				
	Maryland f ahow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Georges 10c. City, Town or Lo Capitol He			side City Limits				
	th with the 23a or 28s	al Director	10e. Street and Number 704 Larchmont Avenue	10f. Zip Code 20743	10g. Citizen of What Country? United States					
. 980	d within 72 hours after death with the Maryland Jiene. I then "natural", or iteme 23e or 28e-f ahow I'ne Medical Evand of must be molified at	by Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 【】No Specify:	nority Yes or No-Rican, etc.) 14. Race - American Inc. Black, White, etc. SpecifyBlack	dian,				
21215-0036	nin 72 hk	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of workii DO NOT use retired)	16b. Kind of Business/Industry	′				
	illed within I Hygiene. other then "		12 Contr	act Specialist	DC Government (First, Middle, Meiden Sumame)	_				
lanc	b d la	To Be	Moses A. Gayles, Sr.		Harrison					
Maryland	od 2 shoulth and 27 is m				nd Route Number, City or Town, State, Zip Code Capitol Heights, MD 2					
Baltimore,	Pages 1 and 3 nent of Health sort: If item 27 ary or other tr		20a. Method of Disposition 1 \(\S \) Burial 2 \(\) Cremation 3 \(\) Removal from State 1 \(\S \) Donation 5 \(\) Other (Specify) 20b. Place of Disposition cemetery, creating the state of Disposition in the state of Dis	matory or other place)	20c. Location - City or Town, S /2012 Brentwood, MD	State				
Balti	permit. Pages Department of I Important: If its any injury or or 2005.			Name and Address of Facility Ope Funeral Homes, Orestville, Maryla	PA., 5538 Marlboro P	ike				
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enson shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.	er the mode of dying, such as cardiac of other typent-	or respiratory arrest, Appl	roximate rval Between et and Death				
	/Medical Examiner		Due to (or as a consequence of):							
	od ansit	Examiner	amine	amine	amine	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
68760,	ificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last Due to (or as a consequence of):							
	E O K		IF FEMALE:							
P.O. Box	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use	Physician/M	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day	Year				
	quires that in signed b uld be deta	by	Part II. Other significent conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contribute to the car 1 Yes 2 No 3 Probably					
of Vital Records,	The law requir ate has been si page 2 should I	Completed			24a. Was an autopsy fi prior to complet death? 1 □ Yes 2 2 7 No 1 □ Yes 2 □	tion of cause of				
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death						
	g Phys er this ieral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	it 3 DOA 4 Intersting Flor	me 5.☐ Tesidence 6 ☐ Other (Specify) 28d. Describe how injury occurred					
Division	tel or Attanding Fisialter death. al Director: After ed in by the funer.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury At home, tarm, st	M 1 Yes 2 No	28f. Location (Street and Number or Rural Rol	ute Number,				
Div	itet or / irs after ral Dire		4 Homicide building, etc. (Specify)		City or Town, State)					
	To the Hospitel or Atti within 24 hours after de To the Funeral Directo completely filled in by th	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.		ed at the time, date and place, and due to the	cause(s)				
	To the within 2 To the complet	Σ	29b. Signature and title of certifier Alarbady Alarbado	29c. License number #6055927	29d. Date signed (Month, Day, December 29					
2	_5		30. Name and address of person who completed cause of death (Item 23a) (Type.	Print) Drine, C,	Leverly Many	and				
	Sta Registr		31. Date filed (Month, Day, Year) DEC 3 0 2011 Server S. Signature DEC 3 0 2011		//					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Dorothy Enoch 5:15p M 2011 Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 11907 Homestead Pl. Waldorf Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □**X**F Months Days Hours Min. (Month, Day 244-58-1746 7 4 Yrs. **Director** North 10-07-1937 Carolina Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director MD Charles Waldorf 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20601 Funeral 11907 Homestead Pl. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black If Yes, Give 3X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supervisor GSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Thaxton Bigelow **James** Alice Μ. 1 and 2 should the filter than 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11907 Homestead Pl. Waldorf, MD 20601 Sharon Enoch-Poynter/Daughter or other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 and Department of Important: If ite any injury or of cemetery, crematory or other place)
Enoch Cemetery 1 XBurial 2 Cremation 3 Removal from State 12-31-2011 Burlington, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonature of Juneral Service Licentee 22. Name and Address of FacilityRonald Taylor II FH tomalde 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications to transcribe the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Pnysician/ a METASTAIC 12 months ADENOCARCINOMA OF COLON Medical resulting in death) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🗆 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death the 9 🗌 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be det þ END STAGE RENAL DISEASE 2 No 3 Probably 4 Unknown Records, Completed 1 🗌 Yes been si should I DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performe this certificate MYOCARDIAL INFARCTION 1 Yes 2 No 1 Yes 2 of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) ၉ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpa 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Division n 24 hours after death. e Funeral Director, A bleted filled in by the fu 1 Tes 2 🗌 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nursa Practionar T. the basis of my knowledge death occurred at the time, date and clue to the cause(s) and manner stated. 29a. Certifier within 2.

To the F 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) DOD 48365 12-27-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9811 MALLARD DR. \$118 **SUPHEMIA** R. BRUMSKINE, MD LAUREL, MD State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tipre of Death Physician/ >4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2222 Alice Avenue #303 Oxon Hill Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept. 9 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Min. Months 1 M 2 F Hours Director 060-30-4865 Usual Residence of Decedent or 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Oxon Hill PG MD 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral death with United States 20745 2222 Alice Avenue #303 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. - O by should be filed within 72 hours after o 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", Completed 3 Widowed 4 Divorced Black Year or Dates Mental Hygiene. larked other than "natur atic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) censed Practical Nurse Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked ဂ္ John Madison other traumatic Helen Edwards .. Page 1 and 2 should tment of Health and M tant: If item 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8709 Susquehanna Street Lorton, VA 22079 19a. Informant's Name/Relationship (Type, Print) Keith Edwards/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 12/30711 1 Burial 2 XCremation 3 Removal from State Riverdale Park Crematory 4 Donation 5 Other (Specify) Riverdale, MD 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee Suitland, MD.20746 3910 Silver Hill Rd., 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mide of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ U disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burlal Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery in the past 12 m 3 Ectopic pregnancy atter ò Month Day 5 Other (specify) 4 Pregnant Pregnant at time of death ☐ Yes 2 the P.O. I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page 2 death? Hospital or Attending Physician: The No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 2 No Hospital: 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 📶 Natural 5 Pending 1 ☐ Yes 2 ☐ No death ☐ Accident☐ Suicide Investigation 24 hours after deat Funeral Director: the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by 4 🗌 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 1 pleted 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and fifte 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

ath (Item 23a) (Type, Print)

who do boile at fault block

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 43025 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Fazenbaker Physician/ Month 12 Day Stanley Eugene 1637 2011 Medical 4a Facility Name (if not institution, give street and number)
Garrett Co. Memorial Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett 0akland If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) **Director** 215-42-4996 1 **X** M 2 □ F 67 10 1944 18 MD Usual Residence of Deceden 10d. Inside City Limits notified at 10a. State 10b. County 10c. City, Town or Location rector 28a-f 1 ★ Yes 2 No MD Garrett 0akland ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 303 Liberty Street 21550 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the miner coa1 event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မှ Belvin Fazenbaker Dortha Glotfelty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Fazenbaker-wife 303 Liberty Street, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/29/2011 4 ☐ Donation 5 ☐ Other (Specify) Deer Park Cemetery Deer Park, MD 22. Name and Address of Facility David A. Burdock Funeral Home, PA 21. Signature of Funeral Service Lice 21 N 2nd St, Oakland, MD 21550 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ MYOCARDIAL INFARCTION 5 minutes disease or condition Medical resulting in death) Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 morths?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year Pregnant at time of death should be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an page 2 s autopsy 24 hours after death. Funeral Director: After this certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 횬 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DEC 29 2011

Date filed (Month, Day, Year,

E. Schwalm, M.D. 311 North Fourth St, Suite II, Oakland, MD 21550 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D27205

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jesus Tan, 4 Broadway, Frostburg, MD

31. Date filed (Month, Day, Year)

DEC 27 2011

21532

Please Type or Print in Black Indelible 19k1 Fresyre AlliCopies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State amend item8 per fh g924 2-27-12 efficate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 23, 12:18^A **Physician** 2011 Edward Savy Grace /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 1200 East West Hwy. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 364-92-5549 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Massachusetts 11☑M 2□F 39 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examiner must be notified at once. 1X Yes 2 □ No Director Norfolk MA Braintree 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 021.84 USA Co C 1st BN 182nd Infantry Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ntrined Forces? 2006-1X Yes 2 No 2011 If Yes, Give Year or Dates: 1X Never Married 2 Married Thai 1 ☐ Yes 21 No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Soldier US Army 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edward G. Grace Leke Chantaua Savvv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leke J. Grace/Mother 42 Milton St. So. Dartmouth, MA 02748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 \$\infty Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 1/18/12 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mann Murphy FH 4510 Wilson Blvd. Arl., VA 22203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) ပ္ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

within 24 hours a To the Funeral C To the Hospital

29b. Signature and title of certifier

Cynthiam Milliams, DO

37-20 Upton ST, N.W. Washington DC

31. Date filed (Month, Day, Year) 1 2 2012 Register's Signature S. Sauce

The law requires that the death certificate be executed

or Attending Physicien: after death.
Director: After this certification by the funeral director, I

Division of Vital Records, P.O. Box 68760,

burial-transit and

use as the

attending physician

cate has been signed by the atter page 2 should be detached for i

has

the Maryland

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

29c. License number

H0058032

29d. Date signed (Month, Day, Year)

October 28, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PM bronas 201 Medical Decembe 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins HIMOTE it . Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours 218-38-5832 Director 1 🗶 M 2 🗌 F 71 April 19, 1940 Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2X No Leonardtown Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20650 20220 USA Beach Comber Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2X Married X Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", White Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) the Loan Officer Bank traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o permit. Page 1 and 2 should be.
Department of Health and Mental
Important; If item 27 is moany injury or otho---: ဂ Virginia Downs Leonard Foley Gray, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 162 California, MD Wife 20619 Lauren Jan Gray 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Mattingley-Gardiner Funeral Home Crematory 1 Burial 2 X Cremation 3 Removal from State 12/31/2011 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St. Leonardtown, MD 20650 uchael 7 Z uner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, if any hading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has funeral director, page 2 this certificate 1 Yes 2 No 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗹 No ပ 1 🗹 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8+1 Rme

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

JAN

aistrar's Signature

600 N. Wolfe St Baltimore Maryland 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Green, Sr. Calvin Anderson 2101 December 26, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 □ F Director 80 224-34-1371 09/10/1931 Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shov event, the Medical Examinar is ust be rigilized at Director 1 ☐ Yes 2 No Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 22872 Lawrence Avenue # 1 20650 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify. Specify 3X Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Construction Heavy Equipment Operator 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise **Gillus** ည Morton Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau 138 Vincent Drive, Emporia, VA 23847 Joyce G. Allen/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rising Star Baptist 12/31/2011 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 Signature of Funeral Service Licensee Jechael Jardiner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** andlac mounte disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to influe distances. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Attending Physician: The law requires that the death certificate be executed milletees Desletes burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Mann of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 ☐ Accident To the Hospital or Attency within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/26/2011 03982

State Registrar James

31. Date filed (Month)

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LEONALDTOWN

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80 Bay

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. 6

DAMALOUS,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 43030 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19, 2011 Laura Ann Cartledge Holman December 2:25 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery Hospice/Casey House Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, Year) **Director** 577-66-0840 1 M 2 X F April 28,1950 South Carolina Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 X Yes 2 No Maryland | Montgomery Gaithersburg ö 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a c Funeral 20878 815 Quince Orchard Boulevard United States Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or iten edical Examiner r Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 X Divorced Completed er than "natur the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Safeway Food lementary/Secondary (0-12) College (1-4 or 5+) 12th grade Store Manager Stores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic eve 2 **Ellihue** Cartledge Harrison Janie Eva 19a. Informant's Name/Relationship (Type, Print(Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 Janice Antoinette Brown 815 Quincy Orchard Boulevard; Gaithersburg, Maryland Department of Healtl Important: If item 2 any injury or other I 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Dec.30,2011 ☐ Burial 2 X Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Rixerdale Park Crematory Riverdale, Maryland Signatu. Funeral Service 22. Name and Address of Facility R. N. Horton Company Morticians, an Inc.;600 Kennedy Street, N.W.; Washington, D.C.2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cirrhosis of the Liver disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-trar resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 X No Month Day Year pec Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice Hospital: 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one)

DHMH 17 Rev 06-2011

State Registrar

29b. Signature and the of certifie

Colen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geoffrey Coleman, M.D.; 1355 Piccard Drive; Suite 100; Rockville, Maryland 20850

29c. License number

D37142

29d. Date signed (Month, Day, Year,

December 19, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25, 2011 Physician/ Clarence Ε. Hill December 1613 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Fort Washington Medical Center Fort Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year Ch. 2 Social Security Number Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**∑** M 2 □ F 103-34-5669 Director 67 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No PG Fort Washington 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 1216 Swann Creek Road 20744 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married XYes 2 🗌 No Baltimore, Maryland 21215-0036 Specify:
Black 1 Yes 2X No Specify: If Yes, Give "natural" 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pentagon Protection <u>Police Officer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental I ည Roscoe Boston <u>Minnie</u> Hill f Health ar, m 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Swann Creek Road Washington, MD. Bettie Hill/wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 1/4/12 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery Cheltenham, 22. Name and Address of Facility Hodges 21. Signature of Funeral Service Licensee & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. P.W. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest struck, or heart failure. List only one cause on each line. Immediate Cause (Final set an Death Physician/ VENTRICU disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine a consequence of Cause (Disease or iinjury that initiated events and burial-trai resulting in death) Last attending physician Physician/Medical Box 68760 the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Hospital Other: မ 1
Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Hatural Accident 5 Pending safter death.

Director: Aff Investigation 1 Yes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Livinaston State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Kenneth Hartman Mont Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WM. Regional Medical Center Allegany Cumberland Social Security Number 218–16–2733 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** reb. 2, 87 Director 1924 Maryland 1 🔀M 2 🗆 F Usual Residence of Deceden 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland at Director notified MD Allegany Westernport 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò ms 23a or must be n Funeral 511 Maryland 21562 United States Ave. Page 1 and 2 should be filed within 72 hours after death items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 X Yes 2 No WW 2
If Yes, Give
Year or Dates. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Amusement Secondary (0-12) College (1-4 or 5+) unknown owner-operator t of Health and Mental Hygi If item 27 is marked other or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Hartman Clara Kerns 19a. Informant's Name/Relationship (Type, Print)
sara Hartman/ wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 511 Maryland Ave, Westernport, Maryland 21562 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If is any injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Peters Cemetery 12/30/2011 Westernport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Wans 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Due to (or as a consequence of): current disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, security to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last DVI - secures burial-tran Due to (or as a consequence of attending physician Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the al detached for been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? COPIS 24a. Was an cate has page 2 autopsy performed 1 Yes 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12/2811 RU59699 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Cumperland, Md. 21502 State

DHMH 17 Rev 06-2011

Registrar

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Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licens	laco			2. Name and Addre		•	Home, E	3runsw	zick MD 2	1716
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Вох	ath ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pregnance Other (specify)	у				23d. Date of de Month	livery Day Year
0	he de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	i inne or de	eath 5	_ Other (specify) _						
0_	uires that the dei signed by the a Id be detached f	by Ph	Part II. Other significent conditions co	ntributing to death b	ut not resu	ulting in the u	nderlying cause giv	ven in Part I	•	23e. Did	tobacco u	use contribute t	o the cause of death?
rds	w require: been sig should be	q pa	Diabetes m	ellitus	,	aspl	nger's			1 🗆	Yes 2	ØNo 3□P	robably 4 Unknown
Records,	ne law re has bee ge 2 sho	Completed	diso-der		,	•	<u> </u>			24a. Was		_ prior to	utopsy findings available completion of cause of
	The ate h page	Com								perf	ormed? 2 No	death?	2 □ No
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital.			0#	han		(Check only			
o	Phys this cral dir	- To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju		ER/Outpatier 28b. Time o	IL 3 DOA	4 L NI	ursing Hom	e 5 Res 8d. Describe		6 ☐Other (Spe	ecify)
O	ding th: After funei	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	Wo	rk?]Yes 2□			,	,	
Division of Vital	Atternor dea	ifica	3 Suicide 6 Could not be determined	28e. Place of In	ury - At ho	ome, farm, st	reet, factory, office		2	8f. Location City or To			ural Route Number,
	tal or A	Certification:	* Florincide	Dulluling, 80	c. (Specify					, o			
	Hospita 24 hours Funeral etely filled		(Check only 2 Medical Exam	sicien: To the best iner: On the basis of	f examinat	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	me, date ar opinion, dea	nd place, a ith occurre	nd due to the	cause(s)) and manner a d place, and du	s stated. e to the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one) 29b. Signature and title of certifier	and manner st	a (80).		29c. Licen	se number			29d. Da	ite signed (Mon	th, Day, Year)
	⊢ 3 ⊢ 8		Vallelaan 1	D Ben	0		T	132	172		17	1/20/3	2011
			30. Name and address of person who	ompleted cause of	death (Item	1 23a) (Type,	Print)					1-01-	1 -
	10		Kathken W S	tem 1	10	610	Ninth	aux	BI	unsi	Dick	M	d. 21716
	Sta Registi		31. Date filed (Month, Day, Year) DEC 222	32. Registi	rar's Signa	ture	backer		,			,	
	negisti	ar	חבל ממ ב	J. J. Janes	2-26-01	10. A	E SOLVE AT						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Kenneth Adam Har	diman Sta 1- For State Registrar	te of Maryland	/ Departmen	nt of Health a e of Death		Hygiene	eg. No. 20	11 4303
Physician/ Medical Examiner	Decedent's Name (First, Middle,					2. Date of Deat Month December	th	3. Time of Death 0831 hrs
And Examiner	KENNETH ADAM 4a. Facility Name (if not institution, 1206 Calvert Road)	4b. City, Town, Rising Su	or Location of Dea		4c. County of De	
Funeral Director	215-82-3572	. Sex 7. A	ge (In yrs. last birthda 36		ear If Under 24H ays Hours M	in.	th(MM/DD/YYYY) 9. For 7, 1975	Birthplace (State or eign ELKTON CountryMARYLAND
the Maryland a or 28a-f show any tiffed at once. Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND CEC 10e. Street and Number		10c. City, Town or RISI	ING SUN		11	0g. Citizen of What C	•
r death with or items 23 must be no Funeral	11. Marital Status 1 Never Married 2 Marr	12. Was Deceden	? X No	3. Was Decedent of If Yes, specify Cub	oan, Mexican, Puer		UNITED ST 14. Race - Am White, etc Specify: WH	erican Indian, Black,
1215-0(136) Id be filed within 72 hours after fental Hygiene. In riced other than "natural", event, the Medical Examiner D Be Conspleted by	15. Decedent's Education (Specif Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, L.	y only highest grade co College (1-4 or	5+) dur	cedent's Usual Occuping most of working I	ife. DO NOT use re		16b. Kind of Busines CONSTRU	•
21215-0(136) could be filed within 7 d Mental Hygiene. s marked other than tic event, the Medica To Be Comple	CARL JAMES HAR 19a. Informant's Name/Relationship	DIMAN, SR.			CINDY reet and Number of	KINKEAD Rural Route Num	nber, City or Town, Sta	
Baltimore, MD 21215-0(136 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that injury or other traumatic event, the Medic To Be Conspl	APRIL REED / SI 20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from S	20b. Place of D	Disposition (Name of or other place)	cemetery,	T, RISINO Date NUARY 5,	20c. Location - City	YLAND 21911 or Town, State T, MARYLAND
Baltim permit. Pa Departmen Important injury or or	4 Dopartion 5 Other Spec 21. Signature of Funeral Service Li		METHOD1	EAST UNITE ST CEMETE 22. Name and Addre 127 SOUTH	ess of Facility CR	2012 OUCH FUN	ERAL HOME,	
Physician /Medical Examiner	23a. Part I. Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease	n each line. a. Cardiac A	rrhythmia	nter the mode of dyir	ng, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
xecuted a and - transit	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cardiomes Due to (or as a cons c. Due to (or as a cons d.	caly with	coronary	artery my	yocardia	l tunnel	
G Esta	X UNPENDED IF FEMALE:			me,g925	3-15-12 8	sm	23d. Date of deliv	erv
). Box 68760 i. the death certificate by by the attending physi wheed for use as the bu Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	1 Live birth 4 Pregnant a 9 Unknown	t time of death 5	Fetal death Street (Specify)	3 Ectopic pregr		Month	Day Year
S, P.O. juires that the signed by lid be detach seed by P.G.	Part II. Other significant condition	ns contributing to deal	th but not resulting in	the underlying caus	e given in Part I.	1 Yes	2 No 3 P	to the cause of death? robably 4 Unknown
tal Records, cian: The law requires certificate has been sig ector, page 2 should be Be Completed	25. Was case referred to medical			26.Pla	nce of Death (Chec	24a. Was a autop: perfor 1 Yes 2	sy prior t med? death	
n of Vi ling Physi After this funeral dir	examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ※ Natural 5 Pendin 2 Accident Investig	28a. Date of Inj (Month, Day,			Other Nurs		Residence 6 🗹 Ott	ner: Scene
Division o Biopital or Attending, 24 hours after death, Funeral Director: After rely filled in by the funeral Certification:	3 Suicide 6 Could in determined	28e. Place of li ined (Specify)		, street, factory, office		or Town, S	tate)	Rural Route Number, City
To the How within 24 h To the Fun completely	(Check only Certifying Pity:	sician: To the best of n ner:On the basis of exa and manner stated	mination and/or inve	estigation, in my opini				the cause(s)
	30. Name and address of person w	ho completed cause of	death (Item 23a)		C.M.E.		January 1, 201	
State		sistant Medical Ex	ode Cianatura		eet, Baltimore,	MD 21223		
Registrar	4 A 3 4 - 41 C3 - F1	012 Besse	v 1. 1	arked .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 201 Physician/ 10:09AM Claude C. Jordan December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Cheverly Prince Georges Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 17 9. Birthplace (State or Foreign . Social Security Number **Funeral** 1 XM 2 - F Hours Min. NC 1942 69 Director 246-66-4259 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at Director 1 Tyres 2 No Capitol Heights PG MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral items 23a United States 20743 4000 Alton Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Pepsi Cola Maintenance other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even any injury or other traumatic even Carrie Daye Felix Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4000 Alton Street Capitol Heights, MD. 20743 Grace Jordan/wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 12/2^{9t}/711 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Riverdale Park Crematory Riverdale, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licenses Suitland, MD. 20746 Silver Hill Rd., 3910 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ▼ No 24a. Was an cate has bage 2 s autopsy performed? Yes 2 No nis certificate h I director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this leted filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

12 10 State

Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifier

(Check only one)

29b. Signature and

title of ce

Name and address of person

31. Date filed (Month, Day, Year) DEC 2 9 2011

HOSPITAL DR

ho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

23

umbli

20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / Department / De	artment of Health and N tificate of Death	nental Hygid	ene	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Gloria Beverly Jones	illicate of Death	2. Date of Death 12 18	Day 201	3. Thie 3 De la 3 E
	Examin		4a. Facility Name (if not institution, give street and number) 5702 Center Dr.	4b City, Town, or Location of Death Temple Hills		4c. County of Deat Prince	Georges
	Funeral Director		5. Social Security Number 7 6. Sex 1 □ M 2 1 F 7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth		thplace (State or Foreign Cuntry) nington DC
	aryland la-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County Prince Georges 10c. City, Town or Loc Temple 10c. City, Town or	Hills			10d. Inside City Limits 1 Yes 2 □ No
	vith the M 23a or 28 st be not	ral Dir	10e. Street and Number 5702 Center Drive	10f. Zip Code 20748	10	USA What Co	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	1 Never Married 2 Married 1 Yes 2 X No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B1	
Baltimore, Maryland 21215-0036	<i>i</i> ithin 72 hou iene. r than "nat i the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ACCO	ent's Usual Occupation kind of work done during most of work D NOT use retired) Duntant Technic	ing	6b. Kind of Business	Industry
/land 2	d be filed w Mental Hygi arked other rtic event, i	To Be	17. Father's Name (First, Middle, Last) Phillip Carter	18. Mother's Name Anna	e (First, Middle, Ma Nowlin	iden Surname)	
, Man	nd 2 shoul salth and I n 27 is ma er trauma		Preneil P. Jones/daughter 19b. Mailin 914	g Address (Street and Number or Rura Eastern Ave. N	al Route Number, C E Washi	ity or Town, State, Zip ngton, D	o Code) OC 20019
imore	Page 1 ar ment of He tant: If iten ury or oth		20a. Method of Disposition 1	sition (Name of large) 12/2	9/11 R	Oc. Location - City or Liverdale	
Balt	permit. Depart Import any inj		21. Signature of Euneral Service Licensee	Name and Address of Facility 35	Eads St	. NE Was	hington, DC
-	Ph _{sician/}		23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis disease or condition	r the mode of dying, such as cardiac o	or respiratory arrest	,	Approximate Interval Between Onset and Death
-	Medical Examiner	_	resulting in death) Due to (or as a consequence of): Gangrene Sequentially list conditions				10/10/11
	ecuted and I-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):	bitus Ulcer			10/12/11
200	cate be executed physician and the burial-transit		d				
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Pregnant at time of death 5 □ Unknown	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
s, P.O	res that the signed by a be detact	by	Part II. Other significant conditions contributing to death but not resulting in the uniform Dialysis, Diabetes Mellitu	nderlying cause given in Part I. IS, Atrial		cco use contribute to	the cause of death?
Division of Vital Records, P.O.	he law requi te has been age 2 should	Completed	Fibrillation, Hypertension, Hemi Effect of Stroke, Colon Cancer,		24a. Was an autopsy performe	24b. Were au prior to death?	topsy findings available completion of cause of
/ital F	Physician: The law r this certificate has beral director, page 2 s	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check		ce 6 Other (Spec	s 2 □ No
on of \	ending Phy ath. r: After this ne funeral d	Certificate: To	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Wonth, Day, Year) 28b. Time of injury	t 3 □ DUA	me 5 L Residen		ity)
Divisi	tal or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Stre City or Town, S	et and Number or Ru State)	ral Route Number,
\	he Hospi in 24 hou he Funer pleted fill	Medical	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death of the death of	gation, in my opinion, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
	To t with To t		29b. Signature and tipe of certifier	29c. License number D60395		d. Date signed (Month	
K	4		30 Diame and saddless of person who completed cause of death/litem 23a) (Type 2	Mercantile L	n. Larg	o, MD. 2	0774
	Stat Registra		31. Date filed (Month, Day, Year) DEC 2 9 2011 Across S. Registrar's Signature S. Across	,			

DHMH 17 Rev 7/2009

VOID

CERTIFICATE

2011-43037

SEE

CERTIFICATE

2011-43622

Completed 4-23-2012 W&

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Lendsey Jenkins 1427 PM Dianna 2 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Hopkins Baltimore The Johns Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–21–2011 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Country)
Marvland 1 □ M 2 🂢 F Months Days Hours Director rone Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d Inside City Limits 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Temple Hills PG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 Funeral 2804 John A. Thompson Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 X Never Married 2 ☐ Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) None None perrit. Page 1 and 2 should be filed w De, artment of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, is Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dionne Watson Jenkins Neal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2804 John A. Thomspn Rd. Temple Hills, Dionne Watson/Mother 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cem. 20a. Method of Disposition Date ■ Burial 2 □ Cremation 3 □ Removal from State 12-30-11 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH 21. Signature of Funeral Service Ligensee Lebones 10583 Middleport In. White Plains, MD 20695 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ nour a. Extreme *Frematurity* disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 22 Weeks overclamosia Materna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of): the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? for Month Year Day Pregnant at time of death Other (specify) detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 X No death? 2 🗌 No certificate 24 hours after death.

Funeral Director: After this certificated filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 \(\sum \) Yes 2 🖟 No မ 1 N Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? (Month, Day, Year) 1 Natural 5 Pending Μ Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Funel completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature RES-000 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Baltimore MD

wolfe St

600

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16 Day 4 2011 Month 2 Miriam L. Jackson

4	Physici /Medic Examin Funeral Director	an cal
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the modest Experiment out be inclined at once.	To Be Completed by Funeral Director
	Physician /Medical	96

4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Washington Medical Glen Burnie Anne Arundel Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Social Security Number 579-72-6712 Days Hours Min. 6 Many 1954 1 ☐ M 2 🔀 F Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County DC Washington 10g. Citizen of What Country? 10e. Street and Number B. St SE 10f Zip Code 20032 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 DXNo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 □Yes 2 →No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Eddie Rich Evelyn Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Johnson/mother 3600 B. St SE #123 Washington, DC 20032 20b. Place of Disposition (Name of Harimon, or other place)
Harimon, Memorial 20c. Location - City or Town, State Landover, MD. 20a. Method of Disposition 12/2^{Pate}/11 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park 804 Georgia Ave Washington, DC 20011 22. Name and Address of Facility
Murray Funeral Services 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed

Physician/Medical

Completed by

Be

Certification: To

Medical

29a. Certifier

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine

23b. Was decedent pregnant in the past 12 months?

I∐Yes 2∰no

Due to (or as a consequence of): Due to (or as a consequence of):

Due to (or as a consequence of)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

3 Ectopic pregnancy

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital:

25. Was case referred to medical examiner? 1 ☐ Yes 2 🔄 No 27. Manner of Death

1 Accident 5 Pending investigation 3 ☐ Suicide 4 Homicide

6 ☐ Could not be determined

2 ★R/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24a. Was an

1 ☐ Yes

26. Place of Death (Check only one)

autopsy performed?

2

28d. Describe how injury occurred

and manner stated 29b. Signature and title of

29c. License number

12 Wareto

29d. Date signed (Month, Day, Year)

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of

1 ☐ Yes 2 ☐ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown

9. Birthplace (State or Foreign

10d. Inside City Limits

X Yes 2 No

Couple

Race - American Indian, Black, White, etc.

Specify:

Black

30. Name and address of p

31. Date filed (Month) DEC 2 9 2011

State

To the within 2 To the I

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ KNOTT UNU Medical 4a. Facility Name (if not institution, give street and number) Ac. County of Death Anne Arundel 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 219-48-1342 **Director** 1 XXM 2 - F 11/28/1947 Wash. D.C. Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Funeral Director 1x x yes 2 No Prince George's Bowie Maryland the 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? тs 23a or must be r 2108 Ardleigh Court 20716 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. "natural", or iter Black, White, etby 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify 3 Widowed 4 Divorced Completed Year or Dates. thand Mental Hygiene.
It is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Entrepreneur Bowie Cab Company Be Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Mary Elizabeth Garretson Clarence Raymond Knott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2108 Ardleigh Ct, Bowie, Md. 20716 Deborah M.Knott/wife Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1)XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md. Veterans Cemetery | 12/27/2011 Cheltenham, Md. Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 16000 Annapolis Road, Bowie, Md. 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final una Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate/be Division of Vital Records, P.O. Box 68760 38 attending IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident 24 hours after death Funeral Director: A filled in by the Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier 🛎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune
completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis, Md. Medical Pavkwar **DEC 2 2** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20 2011 Month Physician/ HERMAN KEMP, JR. 1240 DECEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TALBOT EASTON MEMORIAL HOSPITAL at EASTOR If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days 222-16-6476 Director 1 **X** M 2 □ F 85 MARCH 23, 1926 DELAWARE Usual Residence of Deced 28a-f show 10a. State 10b. Count 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director 10c. City, Town or Location MD CAROLINE **GREENSBORO** 1X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **462 DUTCHMANS LANE** 21639 USA 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 X Widowed 4 Divorced Specify: WHTTF Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4 or 5+) FROZEN FOOD DISPATCHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HERMAN KEMP, SR. ELVA DRAPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA E. BOYD, PERSONAL REP. 26018 FOX GRAPE ROAD, GREENSBORO, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State **X** Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) WOODLAWN MEMORIAL PARK 12/23/2011 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON STREET, EASTON, MD 21601 JOHN R. MERLERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ INTRA CEREBRAL HEMORRAGE DAYS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) TOW APPROVED BY NEDICAL EXAMINER Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical CERTIFICA P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 Yes Yes Division of Vital 25. Was case referred to medical Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) æ examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 1 Natural 2 Accident 5 Pending Investigation 24 hours after deat Funeral Director; 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) trameter D0066441 MD DECEMBER 20 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOLLE RAMESH 2198 WASHINGTON ST, EASTON, MD

Registrar DHMH 17 Rev 06-2011

State

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Pagistrar's Signature

KOLLE RAMESH 31. Date filed (Month DEC 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Connie Johnette Lotter December 2011 12:10 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 20610 Adkins Road Lexington Park St. Mary's Social Security Number 9. Birthplace (State or Foreign Country)

Idaho If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Days Hours (Month, Day Director 518-92-3035 1959 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location by Funeral Director 10d. Inside City Limits 1 Yes 2X No Maryland | St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20610 Adkins Road 20653 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Logistics Manager Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Louis Daniels Jr. Betty Page 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Ray Lotter-Spouse 20610 Adkins Road, Lexington Park, Maryland 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 01/05/2012 Charles Mem. Gardens Leonardtown, Maryland 21. Signature of European Sarvice 22. Name and Address of Facility Brinsfield Funeral Home PA Margaret H. Hicks, M01631 22955 Hollywood Road, Leonardtown, MD. 20653 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ concer disease or condition Medical resulting in death) Due to (or as o nsequence of): 15 months **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): sician a burial-Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 signed by the attending place as in the detached for use as in the detached IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been signated by page 2 should b Completed 2 No 3 Probably 4 Unknown Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner?

1 Yes Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) Natural 5 Pending injury after death.

Director: Aft 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

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completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 00068120 mo 12-30-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23415 Three Notch Rd. Minal Shah, M.D. California, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1:22A. 2. Date of Death December 30, 2011 Physician/ Harvey Howerton Lindsay, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days Hours NOV:19, 1955 Maryland 56 219-64-0346 1 🖾 M 2 🗆 F **Director** 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State notified at Director Beltsville Maryland Prince George's 1 🗆 Yes 2 🔀 No 10f. Zip Code 10e. Street and Number 10a, Citizen of What Country? ö ral", or items 23a or Examiner must be r 20705 United States 4334 Sellman Road Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2X Married 1 ☐ Yes 2 X No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0.12) O'Connell & Laurence of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the I Surveryor Be 18. Mother's Name (First, Middle, Maiden Surname)
Marjorie Talbott 17. Father's Name (First, Middle, Last) Harvey Howerton Lindsay, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4334 Sellman Road Beltsville, Maryland 20705 Sharon Ann Lindsay -wife 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery crematory or other place)
Metropolitan Crematory Date 20c. Location - City or Town, State = 5 Department of Important; If any injury or once. 12/30/2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens DônaraddroBofgwardt Funeral Home, PA Morald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Phylician! Ence halitis disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Metastatic Lung Cancer Sequentially list conditions, Examiner Due to for as a consequence of If any leading to immedicause. Enter Underlying Cause (Disease or injury Pneumonia the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown ior; After this certificate has been signed by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 🗶 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မ 1 🗌 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director; After 1 X Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

Kshama Garg, M.D. HCH1500 Forest Glen Road Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

31. Date filed (Month, Day, Year)

D60826

December 30, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Amend#'s17.18. Perinfmint PCC1-4-12cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Julia Matthews Bernice December 2011 1945 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours Director 577-66-3463 63 1 □ M 2 🛣 F 12/05/1948 DC Usual Residence of Decede 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🔀 Yes 2 🗆 No DC Washington 10e. Street and Number ö 10f. Zin Code 10g. Citizen of What Country? Funeral items 23a 439 Newcomb Street, SE 20032 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black. If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th Dietitian Be Father's Name (First, Middle, Last)
Lawrence Jones 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of permit, Page 1 and 2 should be fill.
Department of Health and Mental Important; If item 27 is marked of any injury or other traumatic eve ပ Catherine Jones Catherine Thomas -0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Matthews/Son 4478 Corral RD, Warrenton, VA 20187 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Tremation 3 Removal from State Riverdale Park Crematory 1/3/2012 Riverdale, MD 4 Donation 5 Other (Specify 21. Signal re Funeral Service Lic Anneand Addess of acility one P.A. 5538 Mariboro Pike/ Forestville, Md. 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Records, P.O. Box 68760 as 1 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ▼ No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \square No 3 \square Probably 4 \longleftarrow Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗌 No 1 🗌 Yes Yes 2 - No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? _2 W No Other: 1 Yes ျ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated . 29b. Signature and title of certifier 29c. License number

State Registrar 3200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

31

31. Date filed (Month, Day,

00060100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elizabeth Ida Marshall 2011 December 11:24 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George's Hospital Center Cheverly Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2**X** F Days Hours 0472711921 Deale, Maryland 216-22-1238 90 Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f Capitol Heights 1 X Yes 2 No Md. P.G. 10e. Street and Number 10f. Zip Code ó 10g. Citizen of What Country? Funeral items 23a 20743 6309 Carrington Court U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after Black If Yes, Give Year or Dates 1 Yes 2X No Specify. Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant Hospital Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Josephine Chambers Joseph Deal 19a. Informant's Name/Relationship (Type, Print)

Jeraldene Shorter/Daughter 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 5438 Addison Rd., Fairmount Heights, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. 01/02/2012 Brentwood, Maryland 21. Signature of Funeral Service Licen 22. Menry dos Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. ance 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death tastatic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury D o (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Day Month Year Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate has been signed I director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 25. Was case referred to medical examiner?

1 Yes 2 You Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentlying Nurse Pranticioner: It the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the cause(s) and manner stated. (Check only on 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D20108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAKESH ARORA, MD 14300 GALLANT FOXLN #222 BOWLEMD 2071

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43046 Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ McCain Brenda Lou December 20 20 il Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Examiner Lanham Doctor's Community Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) Funeral 1 🗆 M 2 🗓 F Months Days Hours 56 220-70-2933 1955 Mary Tand Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director notified Bowie Prince George's 1 Yes 2 X No Maryland | 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? ms 23a or must be Funeral S. A. 20720 U. 6501 Wrangell Road Page 1 and 2 should be filed within 72 hours after death vment of Health and Mental Hygiene.
sant; If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Brenda (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) rtal Hygiene. ed other than event, the N College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lillian Jenette Milstead Robert Carroll Trickey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6501 Wrangell Road, Bowie, Maryland Department of Health Important; If item 27 any injury or other troonce. Timothy P. McCain / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 🗆 Burial 2 🗶 Cremation 3 🗀 Removal from State 12/22/2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral Sovice Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ACUTE MYCCARINITE disease or condition INFARKTION Medical resulting in death) Due to (or as a conseque ce of): Examiner HYPOPTENSION Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury DIABLETE that initiated events resulting in death) Last and burial-trar Due to or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month Day Year Pregnant Unknown Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes FALURE peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an DEPRESSION page 2 s autopsy performed? 1 Yes 2 No has certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation by the f 24 hours after death Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signatu 29c. License number 29d. Date signed (Month. Day, Year) b55559 DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 312 CUNTER THOMAS MASUN 7525 4/20-2 2/6 JEENEWBIND D 31. Date filed (Month, Day, Year) State **DEC 2 2 2011** Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month DECEMBER 7:32 A^M IRMA M. MILLER 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** EASTON TALBOT TALBOT HOSPICE HOUSE . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Days (Month, Day, Y MARCH 03 Months Hours Year) MARYLAND 1 M 2 XF Director 215-36-2253 Usual Residence of Decedent and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show
is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 XNo MARYLAND TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28168 OAKLANDS ROAD 21601 UNITED STATES 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) OWN HOME HOMEMAKER 3 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ DEWEY HENRY MCMAHAN ERMA ROWENA JONES MCMAHAN 1 and 2 should be of Health and Meintern 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28102 BAILEYS NECK ROAD EASTON, MARYLAND 21601 TIMOTHY M. MILLER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🔲 Burial 2 🗓 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 12-20-2011 STEVENSVILLE, MARYLAND 21. Signature FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P. 208 S. HARRISON STREET EASTON, MARYLAND 21601 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complications that ca 23a, Part 1. Enter the disease shock, or heart failure. List only one cause on NANLY CCANCER Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of: cause. Enter Underlying attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 🕱 No for Pregnant at time of death 2 **X** No detached the g 🗌 Unknown is certificate has been signed by director, page 2 should be detact Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26, Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 1 Other (Specify) 1 🗌 Yes 2 🔀 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending work 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0066409 mD30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 302 EASTON, MD 21601 Teal Dr. SUITE 8221 31. Date filed (Month, Day, Year) DEC 21 2011 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 3 per med cert G923 1/18/12 dk

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) McCutcheon Physician/ Glen Rose December 28, 8:00 2011 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany 23108 Red Rose Lane Barton If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min. (Month, Day, Year) 217-28-0010 Director 1 □ M 2 🙀 F 80 Apr. 15 1931 Maryland Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ms 23a or 28a-f sho must be notified at Director MD Allegany Barton 1 Yes 2 No 10f. Zip Code 21521 Citizen of What Country? 10e. Street and Number Funeral 23108 Red Rose Lane United States items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 3altimore, Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home Geriatric Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anthony Bostjancic Brown Emma 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Charles Lee McCutcheon/ husband 23108 Red Rose Lane, Barton, Maryland 21521 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Laurel Hill Cemetery 12/31/2011 Barton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home a 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, ocerd DIT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 use as the IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? for Day Month Year been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 1 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1
Yes 2
No 24a. Was an ieral Director: After this certificate has filled in by the funeral director, page 2: autopsy within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Mesidence} \) 6 \(\text{Other} \) Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Pes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 050844 2011 MSICIAN

State Registrar 31. Date filed (Month, Day Year)

29

Cannetta.

LDVERIA 172

32. Registrar's Signature

MD 912 Seton Drive Cumberland, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

520

		For Amend Item 23. Legistrar 1. Decedent's Name (First, Middle, Last			tificate of De	2.	Date of Deat	h 201	3. Time of Death	
Physicia		Bernadette M. Nic				$ _{\mathcal{D}_{\epsilon}}$	Month ecembe:	r 30, 2011	0846	
Medi Examir	_	4a. Facility Name (if not institution, give			4b. City, Town, or L			4c. County of Dea		
-Xallilli	ICI	St. Mary's Nursin			Leonardt			St. Mary	's	
Funeral		5 Social Society, Number 16 Sov 17 Ago (In vir. last hirthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birtholace (
Director		099-24-3845	⊒м 2 🔀 F 💮 8	2 Yrs.	Months Days	Ma	arch 2	5, 1929 Nĕ	w York	
- MC	1.	Usual Residence of Decedent	10. 6	City, Town or Lo	oction				10d. Inside City Limi	
yland if sho	ict	10a. State 10b. County	ŧ		ation				1 □ Yes 2 🔀	
Mar 28a- notifi	Director	Maryland Calvert		Lusby	10f. Zip Code			10g. Citizen of What C		
th the	<u>e</u>	10e. Street and Number 271 Cove Drive			20657			nited Stat		
th with ms 2 must	Funeral		12. Was Decedent Ever in U	18 13 1		panic Origin? (Specify			nerican Indian,	
r dea	J.F.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	1		panic Origin? (Specify , Mexican, Puerto Ric	an, etc.)	Black, Wh	ite, etc.	
al", c	d by	3X Widowed 4 □ Divorced	1 Yes 2 No If Yes, Give Year or Dates.	1	☐ Yes 2 🗓 No	Specify:		Specify: Wh	nite	
Maryiand ZIZI3-0030 12 should be filed within 72 hours after lith and Mental Hygiene. 27 is marked other than "natural", o r traumatic event, the Medical Exam	Completed	15. Decedent's Ed	ucation	16a. Deced	lent's Usual Occupat	ion		16b. Kind of Busines	s Industry	
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Vica Id be Ment arke	잍	William McGrory								
DEBILITION Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty	pe, Print)					; City or Town, State, 2	Zip Code)	
nd 2 nd 2 ealth m 27		William K. Nichol	s-Son			e, Lusby,		20c. Location - City	- Town State	
P = 1 a		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □		. Place of Dispo cemetery, crer	isition (Name of natory or other place	i	l	•		
Pag men tant:		4 Donation 5 Other (Specif	Ca		National	01/05/	2012 1		, New York	
Dalumore, oermit. Page 1 and Department of Hea Important: If item any Injury or other once.		21. Signatur neral Service Licent		22	2. Name and Address	s of Facility Brin	sfield	l Funeral l	Home, P.A.	
		Edward N. Brins	field, 5f. M	00052	22955 Hol	Lywood Roa	d. Lec	<u>nardtown,</u>	Maryland 2	
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that caused the de ne cause on each line.	eath. Do not ent	er the mode of dying	, Such as Cardiac or i	espiratory arr	C31,	Interval Between Onset and Death	
Frynicien	_	Immediate Cause (Final disease or condition	a Atrio		erilla hi	DN			4	
Medica Examine	_	resulting in death)	Due to (or as a conse	equence of):						
		Sequentially list conditions,	b. Due to or as a cons	EN FO				F-1		
igi gr	٦ <u>.</u>	cause. Enter Underlying Cause (Disease or iinjury	-C.1	1	Hazin	Long		1 Juner		
/60 icate be executed physician and s the burial-transit	edical Examiner	that initiated events resulting in death) Last	C. Due to (or as a cons	equence of):	CICCETT	CERTIFICATION APP	MILLE	CHEAL EXAMINATION		
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four			u			CERTIFICATION				
ords, P.O. box 68. v requires that the death certific is been signed by the attending should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	gnancy	Ectonic pregnancy			23d. Date of		
BOX 68/ death certific he attending led for use as	icia	in the past 12 months? 1 Yes 2 No	4 Pregnant at time		Other (specify)			Month	Day Year	
ut the d uby the	hys	9 Unknown	9 Unknown							
that ned b	by P	Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying cause giv	en in Part I.			to the cause of death?	
JS, uires an sig	ed						10	Yes 2 M/No 3 L	Probably 4 🗆 Unkr	
w req	Completed						24a. Was autor	osv prior	autopsy findings availa to completion of cause	
feC he lav te hav	l mo						perfo	ormed? death	n? Yes 2 □ No	
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in of Vital Hecords, iding Physician: The law requires th. After this certificate has been sig funeral director, page 2 should b	P B	examiner? 1 A Yes 2 100	Hospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 🗆 DOA Othe	r: 4 Nursing Hom	e 5 🗌 Resid	dence 6 🗌 Other (Sp	pecify)	
of g Ph er thi		27. Manner of Death	28a. Date of injury (Month, Day, Year,	28b. Time of injury	work	?	3d. Describe h	now injury occurred		
DIVISION OF tal or Attending P rs after death. al Director: After tl ed in by the funera	fica	1 Natural 5 Pending 2 Accident Investigatio	1		M 1 🗆	Yes 2 No				
IVISIOF I or Attend after death Director: /	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factory, office	28	Bf. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,	
Div spital or ours afte eral Div										
Division of Vital Hecords, P.O. box 65/00 To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical	(O) - I O T Mandisol From	sician: To the best of my kn iner: On the basis of examina	ation and/or invo	etication in my oninic	n death occurred at ti	he time, daté a	and blace, and due to t	ne cause(s) and mainer	
the L thin 24 the F mplet	Me	only one) 3 Certifying Nur	se Practioner: To the best of	f my knowledge,	death occurred at the	e time, date and place,	and due to th	e cause(s) and manner 29d. Date signed (Mo	as stateu.	
10 With		29b. Signature and title of certifier		1 1				17 7 4	1	
		60190	V	10		8923		141 50	12011	
<u> </u>		30. Name and address of person who				Uo11	d MD	20636		
		Vijayal Guduri,	M.D. 24035 T	inree No	occh koad,	Hollywoo	u, EU	20030		
6) Rme	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43050 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec 27, 2011 10:40 P M Dortha Wilkin Orr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours **Director** 230-32-6567 85 1 M 2 X F Virginia Oct 31, 1926 Usual Residence of Decedent f show "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits rector MD Prince George's Hyattsville 1 X Yes 2 ☐ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3906 Livingston Street 20781 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Private Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Harry Wilkin Hester Edna Cavanaugh traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Orr - Husband 3906 Livingston St., Hyattsville, MD 20781 Department of Health Important: If item 27 any injury or other the once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Ft. Lincoln Cemetery 1 ₭ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/2/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Claudette Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Days Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Urinary Tract Infection Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) nding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atter in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Day Year Pregnant at time of death the P.O. signed by: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Anemia 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Myelofibrosis 24a. Was an page 2 autopsy performed? Yes 2 X No 1 Yes 2 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Main Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hou To the Funel completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10

Date filed (Month, Day, Year) Suresh K. Gupta, State Registrar

29b. Signature and title of certifie

only one

9801 Georgia Ave, Ste 220, Silver Spring, MD 20902 32. Registrar Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D32332

29d. Date signed (Month, Day, Year)

12/28/2011

Villiam F Oswald	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No. 2011 4305
Physician/	Registrar 1. Decedent's Name (First, Middle,Last) William F Oswald 2. Date of Death Month Day Year December 27, 2011 1717 hrs
Medical Examine	
	4a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center Cheverly 4b. City, Town, or Location of Death 4c. County or Death Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	530-50-0250 XXM 2 F 58 Yrs. Months Days Hours Min. Oct. 5, 1954 Country) NJ
Þ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
ow any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Inside
the Maryland a or 28a-f sh tiffied at once Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
tth the Maryland 23a or 28a-f sho notified at once	3025 OTTER SQUARE APT.B 20602 U. S. A.
r death with or items 23 must be no Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 14. Race - American Indian, Black, 15. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 16. Was Decedent Ever in U.S. 17. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 18. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent Ever in U.S. 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent Ever in U.S. 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent Ever in U.S. 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 19. Was De
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urs afte	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
136 thin 72 hours are than "natural edical Examin	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)
5-0036 ed within 72 hour sygiene. other than "nature Medical Exau	12 AUTO MECHANIC FORD MOTOR CO. 13. Fether's Name (First, Middle, Last) 14. Fether's Name (First, Middle, Maiden Surname)
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica To Be Comple	The dutier a realite (time), intended, Eacty
1D 21215 2 should be file and Mental H 27 is marked matic event, fi	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Inter If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	APRIL FARMER/DAUGHTER 3025 OTTER SQ. APT. B WALDORF, MD 20602 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, April 20c. Location - City or Town, State
nore, MI ages 1 and 2 s nt of Health a tt: If item 27 other traum	1 Burial 2 x x cemation 3 Removal from State crematory or other place) DECEMBER
Baltimore, comit. Pages 1 ar Department of Hee Important: If ite Injury or other tr	A Donation 5 Other Specify: METRO.CREMATORY 31,2011 ALEXANDRIA, VA
Baltimore permit. Pages I Department of I Important: If injury or other	21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interview
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease
LAdilliller	or condition resulting in death) Due to (or as a consequence of):
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause, Enter Underlying Cause
ted nisit Examine	Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
, P.O. Box 68760, res that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit of by Physician/Medical Ex	d. AMENDED 23a,pt.II,27,per me,g924 2-23-12 sm
60, tte be e hysicia e buria	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
687 ertifica ding p e as th	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specific)
). Box 6876 the death certificate by the attending phyched for use as the Physician/M	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown
O. E at the d by the trached	
S, P.C.	Diabetes Mellitus 1
cords law requi	autopsy prior to completion of cause of performed? death?
tal Records, I tian: The law requires certificate has been sig ector, page 2 should be	1 ✓ Yes 2 No 1 ✓ Yes 2 No
ician: s certification	25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other:
n of Vit ing Physic After this funeral dir	27. Mapper of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
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Division of Vital Records, P.O. Box 6876 spital or Attending Physician: The law requires that the death certificate nortal Director. After this certificate has been signed by the attending phy filled in by the funeral director, page 2 should be detached for use as the I.Contrification: To Be Committeed by Physician/M.	2 Accident A
Divis ospital or A hours after mneral Dire y filled in b	
Division of Vital Records, P.O. Box 6876(To the Bospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the bedievel Certification: To Be Completed by Physician/Ma	(Check only one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F . S & S	A I
	4 CCC December 29, 2011
	30. Name and address of person who completed cabse of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
Stat	31. Date filed (Month, Day, Year) 32. Registrar's Signature
Registra	1AN 1 2 2012 Jener B. Galler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 28, Geraldine Sara Porter 20^T1 6:45A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ft. Washington Prince George Ft. Washington Health&Rehab Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 206-24-9598 Director 1 - M 2 X F 78 8/2/1933 Pennsylvania Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits with the Maryland at 10a. State 10b. County Director an "natural", or items 23a or 28a-f s Medical Examiner must be notified 1 Yes 2 No Maryland Prince George Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9701 Kisconko Road 20744 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph G. Braund Sara I. Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Porter/Daughter 18 King James Place, Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 1/4/2012 Clinton, MD 5 Other (Specify) 4 Donation 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatu 6160 Oxon Hill Rd. Öxon Hill, MD 20745 also Part 1. Enter the disease, or complic shock, or heart failure. List only one nons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line Approximate Interval Between (ance Vulla Immediate Cause (Final Me Onset and Death Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events and -trar Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
• Enhours after death.
• Funeral Director: After this certificate has been signed by the attending physicial elely filled in by the funeral director, page 2 should be detached for use as the bun elely filled in by the funeral director, page 2 should be detached for use as the bun. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier pe, Print) 12-28-1 Viring Stand At los ft wash, to Mo

State

Registrar DHMH 17 Rev 06-2011 701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M-1

			1 - State Amend Items 2 Registrar	7,28a-f pe	ryland/Dap me,g923	tificate of De	ealth and Meath	lental Hyg	jiene	43053
		-	Decedent's Name (First, Middle, Last			imouto or be	Jatiri	2. Date of Deat		3. Time of Death
п	Physicia Medio		Hazel F	Phill:	ippi			12 1	9 2011 Year	10:00 A ^M
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			Oakland Nursing & 5. Social Security Number 6. Se		ter In yrs. last birthday)	Oakland If Under 1 Year		8. Date of Birth	Garret	
	Funeral Director			M 2 X F	89 Yrs.		Hours Min.	(Month, Day,	Year) Co	thplace (State or Foreign untry)
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	arylan a-f sh fied a	Director			10c. City, Town or Loc	cation				10d. Inside City Limits 1 ✓ Yes 2 No
	the Ma or 28		MD Garret 10e. Street and Number		0akland	10f. Zip Code			10g. Citizen of What Co	
	with t	Funeral	134 N 2nd St. Apt	1		2155	0		USA	,
	death item	Fun	11. Marital Status	12. Was Decedent Eve Armed Forces?		Vas Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spe	cify Yes or No-	14. Race - Ame	
36	a filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give	o	☐ Yes 2 🔀 No		,	Black, White Specify:	
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121	ed within Hygiene. other tha	Be C	12. Father's Name (First, Middle, Last)			clerk			retail	
Maryland	ould be filed of Mental Hyg marked oth	To E	Henry Davis			1	18. Mother's Name	e (First, Middle, N e Auwaeı	·	
ary	1 and 2 should be of Health and Ment fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailin	a Address (Street and			City or Town, State, Zij	o Code)
Σ	and 2 sl Health a tem 27 is		Linda Friend-daug	ghter	.1.				1, MD 21550	
ore	ge 1 ar nt of He : If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispos		- 1 -)axe	20c. Location - City or	
Baltimore,	t. Page 1 rtment of rtant: If it rjury or o		4 Donation 5 Other (Specify)	Garrett C				Oakland,	
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	en /	22	Name and Address N 2nd St	^{of Facility} Dav: • Oakland	id A. Bu	rdock Fune	ral Home PA
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de eq.	Physician/		Immediate Cause (Final disease or condition resulting in death)	a	MENTI	q				Onset and Death
Second .	Medical Examiner		resulting in death)	Due to (or as a co	consequence of):					
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	tte be executed hysician and the burial-transit	al E	resulting in death) Last	Due to (or as a co	onsequence of):		CERTIFICATION	DE ONED BY ME	DICALEARM	
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687	death certificate be executed the attending physician and ed for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				23d. Date of de	livery
		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 9 4 Pregnant at til 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as		9 ☐ Unknown Part II. Other significant conditions co		not resulting in the u	nderlying cause giver	n in Part I	220 Did tob	pacco use contribute to	the enuce of death?
s, P	ires th signe Id be (Completed by	Leaver a	ad hu	merus	ForAct	11 8 F S	1 🗆 Ye		robably 4 Unknown
ord	v requ	olete	A Milmaille	ANGENESSI	ilb A	Chacia		24a. Was ar	n 24b. Were au	topsy findings available
3ec	The law ate has page 2	mo	Corandin	ANTERY	1186	40		autops perforr 1 \sum Yes 2	med? death?	completion of cause of
tal	sician: The certificate rector, pag	Be C	25. Was case referred to medical examine?	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	11 (71-1	26. Place	e of Death (Check		2 C NO 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	5 2 🗆 140
Ξ	Physic this ce al dire	은	1 Yes 2 No		2 ER/Outpatien		-	me 5 🗆 Reside	ence 6 Other (Spec	ify)
n o	ding F h. After funer	ate	27. Mann of Death 5 ☐ Pending	28a. Date of injury (Month, Day, Y. 10/17/20]	(ear) 28b. Time of injury Unknow	28c. Injury a work? IN M 1 ☐ Ye	v.	8d. Describe ho Subject	w injury occurred	
Division of Vital Records,	Atten er deal ector: by the	Certificate:	2 X Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	- At home, farm, stre					ral Route Number,
Ωį	ital or irs afte ral Dir lled in			Home building, etc. (\$				Apt. 1,0	uak rana, mu	2nd Street,
	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	(Check 2 \(\sum \) Medical Examin	ician: To the best of my ner: On the basis of exan e Practitioner: To the b	mination and/or investi	gation, in my opinion.	death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated
	To t To t Com		29b. Signature and title of certifier	/		29c. License n	umber		9d. Date signed (Mont)	
			14411			D0061	901		12/20	111
		A	30. Name and address of person who co Kenneth Buczns				reet. Su	ite T.	Oakland M	n 21550
I	Stat Registra		31. Date filed (Month, Day, Year) DEC 2 0 20	32. Redistrar's	Signature	ares			Janzanu , II	~ ~ £ J J V
				700,00						

State of Maryland / Department of Health and Mental Hygiene = State Registrar Amend#18. Per FHPGC12-29-11cr Certificate of Death Decedent's Name (First, Middle, Last)

Theodore Robinson 2. Date of Death Theodore Month Physician/ 10:00 AM Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Montgamery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 77 235-52-2156 1**√** M 2 □ F 1934 West Virginia Director June 21, Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a, State Director or 28a-f sl 1 X Yes 2 No District Hts. Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ō pe items 23a oner must be USA 20747 Funeral 3002 Walters Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black White, etc. o 1 Never Married 2X Married ò 1 Yes 3altimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed ROBINSON Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4 or 5+) PVI. the Construction and Mental Hygier is marked other t other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rhoda Unknown Williams Crosby Jake Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) THEODORE Department of Health ar Important: If item 27 is any injury or other trau 3002 Walters Lane District Hts. MD Rebecca Robinson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition **★** Burial 2 Cremation 3 Removal from State Jan. 3, 2012 Suitland, MD 4 Donation 5 Other (Specify) Washington National 21. Signature of Funeral Service License Pridgen Funeral Service, PA Rd. Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that vaused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final CARDIO PULMONARY Physician/ HRREST disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CARDIOMYOPATHY STAGE LICHEMIC ND Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exam death certificate be executed and I-tran Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 END STAGE RENAL DISEASE 2 ☐ No 3 🗙 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an CHRONIC OBSTRUCTIVE LUNG DISEASE autopsy certificate has performed? death? 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA Director: After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d Describe how injury occurred 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: I or Attending F after death. XNatural 5 Pending Accident
Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 2011 cv 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Molecular Drive, Ste 2 Rockville, Md. 20850 10110 State DEC 2 9 2011 Registrar

			. For Stat	e of Maryland / De			1ental Hyg	giene		
		1	State Registrar	С	ertificate of D	eath		Reg. No. 2	11 43055	
	Physicia	- /	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month 2 /		Year 3. Time of Death 1427 M	
	Medic	al	Carl L. Roberts, Jr. 4a. Facility Name (if not institution, give street and	d number)	4b. City, Town, or	Location of Death	12/	4c. County of Death		
	Examin	er	AAMC	,	Annapo				Arunde1	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Birthplace (State or Foreign Country)		
	Director		577-32-5668 1 XXM 2 ☐ Usual Residence of Decedent	∃F 85 _{Yrs}	5. ·		9/16/1	926	DC	
	and show tat	jo	10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits		
	Maryl 28a-f otified	Director	MD Anne Arundel	0	denton			1 ☐ Yes 2XX No		
	th the 3a or t be n		10e. Street and Number		10f. Zip Code	1112		10g. Citizen of W	hat Country? USA	
	ath wi	Funeral	1341 Meyers Station R		3. Was Decedent of His If Yes, specify Cubar	1113 spanic Origin? (Spe	cify Yes or No-	14. Race	- American Indian,	
9	ter de	by F	1 Never Married 2 Married	Yes 2 No WWII	If Yes, specify Cubar		Rican, etc.)		k, White, etc. White	
003	ursaf tural", alExa	ted	3 XX Midowed 4 □ Divorced Year	s, Give or Dates.				Specify:		
15-	72 ho n "nat fledica	Completed	15. Decedent's Education (Specify only highest grade comp.	leted) (G	ecedent's Usual Occupa ive kind of work done d e. DO NOT use retired)	ition uring most of worki	ing	16b. Kind of Bus	siness/Industry	
212	within giene. er tha		Elementary/Secondary (0-12) Collection Colle	ge (1-4 or 5+)	Warehousem	an		Safewa	ay Grocery	
nd D	be filed within 72 hours after death with the Manyland ental Hygiene. ked other than "natural", or items 23a or 28a-f show tic event, the Medical Examiner must be notified at its event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam-		Maiden Surname)		
yla	should be file and Mental I is marked o raumatic eve	은	Carl L. Roberts, SR.				Taylor	011 # 01	7. 0. 4.1	
Īã	2 sho th and 27 is r traun		19a. Informant's Name/Relationship (Type, Print) Ronald Roberts Son		lailing Address (Street a					
ē,	nit. Page 1 and 2 should be artment of Health and Men ortant: If item 27 is marke injury or other traumatic e.		20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other place		Date		City or Town, State	
<u>m</u>	Page nent c ant: If any or		1 ☐ Burial 2 XXcremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	Iron State	c Cremator	·	3/2011	Glen Bu	rnie, MD	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 sho Department of Health an Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licensee		22. Name and Addres					
	<u> </u>		23a. Part 1. Enter the disease, or complications	that caused the death. Do not	12 Ridgely				401 Approximate	
١,	and in the control of		shock, or heart failure. List only one cause	on each line.					Interval Between Onset and Death	
	Medical			eta Start Coue to (or as a consequence of):	sion can	Lev				
	Examiner	<u>.</u>	Sequentially list conditions, b. ——							
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to for as a consequence oil.						
	xecute n and al-trar	Еха	that initiated events C	ue to (or as a consequence of):						
09	ite be executed hysician and the burial-transit	dical	d							
3876	eath certificate attending phy of for use as th	/Mec	IF FEMALE:	a automo of prognancy						
Box 687	ath cel	cian/	in the past 12 months?	s, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Date Mor	e of delivery hth Day Year	
m M	he deg y the g ach e d	Physician/Me		Unknown						
P.0	requires that the der been signed by the s should be detached	by P	Part II. Other significant conditions contributing	g to death but not resulting in t	he underlying cause giv	en in Part I.			ibute to the cause of death?	
ďs,	equires sen sig rould b					-		Ten	3 Probably 4 Unknown	
<u>0</u>	has be	Completed					24a. Was autop perfo	osy pormed? d	Vere autopsy findings available prior to completion of cause of death?	
Ä	n: The ficate or, pag		25. Was case referred to medical		26 Pl	ace of Death (Chec	1 Yes	2 No 1	Yes 2 No	
Vita	ysicia s certi direct	To Be	examiner? 1 Yes 2 No Hospital:	1 Inpatient 2 ☐ ER/Outp	Othe	ar		dence 6 Othe	er (Specify)	
ot	Attending Physician: The la ar death. ector: After this certificate ha by the funeral director, page		27. Manner of Death 28a. 1- Natural 5 ☐ Pending	Date of injury (Month, Day, Year) 28b. Tim	iry work	.?	28d. Describe h	now injury occurre	ed	
ion	ttendi death. tor: A / the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	Place of Injury - At home, farm		Yes 2 □ No	28f Location /5	Street and Number	er or Rural Route Number,	
Division of Vital Records, P.O.	al or A safter I Direct			building, etc. (Specify)	, 0,		City or Tou			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examiner: On t	the best of my knowledge, de	nvestigation, in my opinio	on, death occurred a	it the time, date a	and place, and due	e to the cause(s) and manner stated.	
	thin 24 the F	Me	only one) 3 Certifying Nurse Practi 29b. Signature and title of certifier	tioner: To the best of my knowle	edge, death occurred at t	he time, date and pl	ace, and due to t	the cause(s) and m	nanner as stated. d (Month, Day, Year)	
	7.≱ 5 .8		TO A CONTROLLED ON THE CONTROL	2,00		2036			19-11	
	TXX		30. Name and address of person who complete	d agus of death (Itom 23a) (Tu	ne Print)					
	45		Resecca Powell	2001 Medica	al Parkw.	ay Ar	apolis	MD 7	21401	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 2 2011	2001 MCALA 32. Registrar's Signature	pare		_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ РМ Carrollton Edward Reese 2011 December 1:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 44996 Blackistone Circle **Hollywood** St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**★** M 2 | F Hours Min. 577-09-9135 12/26/1915 96 Pennsylvania Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland St. Mary's 1 Yes 2X No **Hollywood** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or edical Examiner must be Funeral 44996 20636 Blackistone Circle USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3

Widowed 4 □ Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Cartographer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marion Edward Reese Isabelle Ada Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Joseph Reese - Son 45035 Blackistone Circle Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 & Burial 2 Cremation 3 Removal from State St. John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 01/05/2012 Hollywood, MD Mattingley-Gardiner Funeral Home, 41590 Fenwick St. Leonardtown, MD 20650 Jaroline 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ prostate concer years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as ding IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 25. Was case referred to medical 26 Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 KNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death filled in by the funeral 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred injury 1 Matural 5 Pending 24 hours af er death Funeral Director A 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one) within 2

(10) pme

Jeffrey C. Brown, M.D. 31. Date filed (Month, Day, Year) JAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and title of certifie

29b. Signati

26840 Pt. Lookout Rd. Leonardtown, MD

State

Registrar

D42597

29d. Date signed (Month, Day, Year)

12-30-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2011 11:58 PM RHODERICK December LEE HAROLD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick <u>Frederick Memorial Hospital</u> 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Y Maryland 1924 87 Director 214-32-2727 May Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10b. County 10d. Inside City Limits death with the Maryland 10a State 10c. City. Town or Location Director 1 Yes 2 No Maryland Damascus Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 9936 Moxley Road 20872 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. ō þ 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ■ No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturary injury or other traumatic event, the Medicall once." 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Fuel Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Charles V. Rhoderick Mary E. Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Peggy Fleming, Daughter 1008 Midvale Avenue, Mount Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Providence Meth. Cem Dec. 23, 2011 Monrovia, Maryland 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 20872 eral Service Signati used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Inset and Death Part 1. Enter the disease, or complication, that shock, or heart failure. List only one cause on a Immediate Cause (Final expa curbation Phylician/ disease or condition Medical resulting in death) **Examiner** day Sequentially list conditions Examiner ir any, leading to immediate cause. Enter Underlying requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death Unknown 2 No detached 9 Unknown o signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by D1960 25 1 X Yes 2 No 3 Probably 4 Unknown Records, Bladder 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law certificate has performed Yes 2 page 2 No 1 Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be of Vital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 မ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 X Natural 5 Pending work Division 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Fegistra s Signature

EVILLAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death December 28, 2011 Physician/ Hettv Harkness Shear 23:30P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery . Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 262-50-3939 Nov. 8, 1915 Director 1 □ M 2 🗓 F 96 Washington, DC ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 X No 10g. Citizen of What Country? Funeral 3128 Gracefield Road, HS#411 20904 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business/Industry should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Piano teacher self employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Harkness Beulah Dalzell other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or are Myron Shear -son 3364 Tanterra Circle Brookeville, Maryland 20833 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 \square Cremation 3 \square Removal from State Fort Lincoln Cemetery 1/4/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Donald Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Pneumonia Sequentially list conditions. rf any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has le 2 pade performed? Yes 2X No 24 hours after deatn.

• Funeral Director. After this certificate I letely filled in by the funeral director, pag 1 ☐ Yes 2 💢 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 068962 12/29/11 agenas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laguras-Fitta HCH 1500 Forest Glen Rd. SilverSpring, MD 20910 State JAN I Registrar

Melissa Ann Schoch	State of Maryland / Department of Health and Mental				
1- For State Registrar	Certificate of Death	Reg. No.	201		4305
Physician/ 1. Decedent's	Name (First, Middle,Last)	2. Date of Death		3. Tim	e of Death

		1- For State Registrar	tate of Maryland / L		ate of D		wentari	,,	Reg. No. 20	11 4305
Physic Medical Exam			•					2. Date of Dea		3. Time of Death 0655 hrs
<i>i</i> *		Melissa At 4a. Facility Name (if not instituti			4b.	City, Town, or Lo	ocation of Dea		er 10, 2011 4c. County of	
		Jasper Riley Road .5	miles E of Rt. 219			Dakland			Garrett	
Funeral Director		5. Social Security Number		n yrs. last bir	-	If Under 1 Year Months Days	If Under 24H	lrs. 8. Date of Bi	irth (MM/DD/YYYY)	9. Birthplace (State or oreign
		216-04-9827 Usual Residence of Decedent	1 M 2 ▼ F 3	1	Yrs.	Days	110013	09/14	4/1980	Country) MD
any		10a. State 10b. County	100	c. City, Town	or Location				·	10d. Inside City Limits
and show	5	MD Gari	rett	0ak1	and					1 Yes 2 No
Maryland '28a-f sho d at once.	Director	10e. Street and Number				Of. Zip Code		1	10g. Citizen of What	: Country?
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at once.		318 Doc Bernar				21550			USA	
eath wi	Funeral	11. Marital Status 1 Never Married 2 X M	12. Was Decedent Eve arried Armed Forces?		13. Was D	ecedent of Hispa specify Cuban, M	nic Origin? (: lexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - / White, e	American Indian, Black, etc.
fter de I'', or		3 Widowed 4 Div	orced If Yes, Give Year	No	1 Ye	s 2 No s	specify:		Specify:	White
2 hours a "natura	ed by	15. Decedent's Education (Spe	or Dates: ecify only highest grade completed	ted) 16a.	Decedent's U	Jsual Occupation of working life. Do	(Give kind of	f work done	16b. Kind of Busin	ness/Industry
136 thin 72 lee. than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			Trainer		eurea)	Food	Service
5-00; led with Hygiene other t	Som	17. Father's Name (First, Middle			Clew			ne (First Middle	Maiden Surname)	Service
21215-0036 wild be filed within 7 Mental Hygiene, marked other than	Be	David C. Ste	yer					E. Coope		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 she injury or other traumatic event, the Medical Examiner must be notified at once	ှင	19a. Informant's Name/Relations							nber, City or Town,	
p, MD and 2 sho (ealth and tem 27 is		Adam T. School 20a. Method of Disposition				Bernar		, Oaklar	nd, MD 215	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation	n 3 Removal from State	cremate	ory or other p	olace)				
altin mit. P partme portan		4 Donation 5 Other S		wnite				2/14/201		and, MD ineral Home, I
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Physician // Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that caused the on each line.	death. Do no	t enter the m	ode of dying, suc	ch as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a conseque	n=0 =f\;						Death
		Sequentially list conditions,	b	nce or).						
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	nce of):	_					
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760, cate be ex physician the burial	Medical	IF FEMALE:	23c. If yes, outcome of	pregnancy					23d. Date of del	live a
		23b. Was decedent pregnant in the past 12 months?	e 1 Live birth	2	-	eath 3 E	Ectopic pregn	ancy	Month Month	Day Year
Box 687 death certific the attending r d for use as th	Physician/	1 Yes 2 V No 9 Unk	Pregnant at time	of death 5	Other	(Specify)				
c, et the		Part Ii. Other significant conditi	ons contributing to death but	not resulting	in the under	lying cause giver	n in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
S, P.C uires that n signed	ed by							1 Yes	2 No 3	Probably 4 Unknown
Cords, law requir has been s	plet							24a. Was a autops	sy prior	e autopsy findings available to completion of cause of
tal Rec	Completed							perform	med? deat 2 No 1 ✔	
Division of Vital Records, rat or Attending Physician: The law requir rs after death. In Director: After this certificate has been so led in by the funeral director, page 2 should the contractions of the funeral director.	8	25. Was case referred to medical examiner?	Hospital:	s Coro	·	LOW	Death (Check			
of Vit ing Physic After this	밝	1 Yes 2 No 27. Manner of Death	28a. Date of Injury		tpatient 3 ime of Injury	DOA Othe	114141		Residence 6 🗸 0	ther: Scene
ion tendin	Certification:	1 Natural 5 Pend 2 Accident Inves		0640	hrs		2 No		senger in car th	at struck tree during
ivis lor At after d Direct I in by	Ę	3 Suicide 6 Could	inot be 28e. Place of Injury -	At home, far	m, street, fac	ctory, office buildi		28f. Location (S	treet and Number or	Rural Route Number, City
Ospital hours uneral		4 Homicide	mined (Specify) Local S						oad .5 miles E of	Rt. 219, Oakland, MD
Division of To the Hospital or Attending Phe Within 24 hours after death. To the Funcral Director: After to completely filled in by the funeral	Medical	(Check only Certifying Ph	ysician: To the best of my kno	wledge, deat on and/or in	th occurred a vestigation, in	t the time, date a n my opinion, dea	nd place, and ath occurred a	I due to the cause at the time, date a	e(s) and manner as a and place, and due to	stated. o the cause(s)
F 3 F 3	\$	29b. Signature and title of certifier	and manner stated.	1128	4	29c. License nu	mber		29d. Date signed (Month, Day, Year)
		Occla Va	the Veel	140)	O.C.M.E			December 11,	2011
1.	1	30. Name and address of person Victor Weedn MD JD	who completed cause of death (Assistant Medical Exa	,	00 W B-	Itimes Ot	N D-11	MD 0105	^	
Sta	le i		32 Redistrar's Sig				a, Baltimo	re, MD 2122	3	
Registi	ar	31. Date filed (Month, Day, Year) DEC 1 4	2011 Jeneur	B.	park			1		
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DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 3. Time of Do 2. Date of Death Physician/ December 19,2011 Streicher 6:00 Lloyd I. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 723-03-5290 **Director** 1 X M 2 D F 84 August 25, 1927 Illinois la or 28a-f show be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County Director Fort Washington Maryland Prince George's 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20744 7403 Jaywick Ave. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1947
If Yes, Give 59 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. 59 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Electronics Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Lucy Hortense Cotton Streicher Sebastian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7403 Jaywick Ave., Fort Washington, MD 20744 Thelma J. Streicher - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery 12/29/2011 Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signature of Juperal Service Lic 61600xon Hill Rd., Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last ig physician and as the burial-tran Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 been signed by the attending should be detached for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Year 1 Yes 2 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 Yes 2 No director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2V No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Mannet of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 20 eted cause of death (Item 23a) (Type, Print) Name and address of person who con Bow 31. Date filed (Month, Day, Year, State DEC 2 2 2011

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. ^D2011 7:50 A Ruth M. Schumacher 18. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Months (Month, Day, Year) **Director** 327-20-9319 1 🗆 M 2 🗓 F 86 Yrs. March 8,1925 Illinois ams 23a or 28a-f show r must be notified at 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director 1 Yes 2 X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 624 Beach Drive 21403 United States items ? Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten edical Examiner Armed Forces Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify White Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of 27 is marked of traumatic ever 2 Effie Hanson Harold Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a William K. Schumacher/Husband 624 Beach Drive, Annapolis, MD permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troones. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 12/22/2011 | Baltimore, MD Signature of Funeral Service Lig 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final 50 Physician disease or condition resulting in death) Medical Due to (or as / consequence of): Examiner VINCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s has autopsy performed? death? certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA After this 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury Investigation Accident 24 hours after deat Funeral Director. 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical within 24 hou

To the Funer

completely fi 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentifying Nurse Practition of Totals and In your object occurred at the time, date and place, and due to the cause(s) and manner stated. (Check the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State strar's Signature

Registrar

			For State Registrar		State	oi iviaryi	апа / Бер Се	rtificate			u iviei	Rai Hyg	eg. No. Z	201		4308	52
	Physicia	n/	1. Decedent's Name									Date of Deat Month	n Dav	Year		3. Time of Death	
	Medic	al	4a. Facility Name (if n		Schuster			Tab City Tr	own orlo	cation of De	-	ecembe		, 201 unty of Dea		10:29 A	IVI
	Examin	er	Bowie He			112017			Bowie					nce G		ge's	
	Funeral Director		5. Social Security Nur 213–44–37	mber	6. Sex 1 🛛 M 2 □ F	7. Age (In y	rs. last birthday)	If Under 1 Months		Under 24 H Hours N	/lin.	Date of Birth (Month, Day,		Co	ountry)	e (State or Fore	∍ign
			Usual Residence of	Decedent	1 2 2 W 2 C .							Sep. 17	, 19	43 6	erma	Inside City Lim	aita .
	ryland -f sho ied at	Director		10b. County	George'		. City, Town or Le	Bowie							100.	1 Yes 2 X	
	or 28a	Dire	MD 10e. Street and Numl		George	5		10f. Zip 0				1	0g. Citizer	n of What C	Country'	?	_
	with t	Funeral	3405 Chu	ırch Ro	ad				2072	21				U.S.	Α		
	death r items ner m	Fun	11. Marital Status	. . .	Armed F		n U.S. 13.	Was Decede If Yes, specif	nt of Hispa y Cuban, I	anic Origin? Mexican, Pu	Specify uerto Rica	Yes or No- an, etc.)	14.	Race - Am Black, Whi			
336	s after al", or Exami	d by	1 Never Marrie		ed 1 L Yes If Yes, Gi Year or D	2 X No live X No Dates.		1 Yes 2	X No	Specify:			Spe	ecify: W	hit	е	
Maryland 21215-0036	hours "natur	Completed	(Spec		t's Education at grade completed	d)	16a. Dece	edent's Usual kind of work	Occupation done duri	on ing most of	working		16b. Kind	of Business	s/Indus	try	
121	thin 73 ene. than he Me	Som	Elementary/Secor		T	1-4 or 5+)		00 NOT use r urchas		Agent			Elec	trica	1 C	ontract	ing
מ	iled wi I Hygie other rent, t	Be (17. Father's Name (F	irst, Middle, L	ast)					8. Mother's	Name (Fi	rst, Middle, N	faiden Sur	name)			
ylar	ld be f Menta arked atic ev	To	Franz Jo	seph S	chuster						_	Marie					
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re,			Rosemary 20a. Method of Dispo	osition		21	Oh Place of Disc	Churc osition (Name	e of	au, be	Date			tion - City o	or Town	, State	
E E	Page 1 ment of ant: If it ury or o	1	Burial 2 4 Donation		3 ☐ Removal from Decify)	n State	cemetery, cre ęsurrect	ematory or oth Lion Ce	her place) emete	ry 12	/23/	2011	Clint	on, M	1D_		
Baltimore,	permit, Page Department of Important: If any injury or once,	(21. Signature of Fun	eral Same	MIN	DD		22. Name and							207	15	
	= 1117.		23a. Part 1. Enter th	ne disease, or	complications that	caused the							_		A	pproximate terval Between	- 1
2	Physician/		shock, or heart Immediate Cause (F disease or condition	inal	nly one cause on e		ndia	Oin.	lan	ect	Por	2				nset and Death	
A	Medical Examiner		resulting in death)		Due 4	or as a cor	sequence of):	/							Ī		
		Jer	Sequentially list con	nditions, mediate	b. Due to	or as a cor	nsequence of):								+		
	uted d ansit	Examiner	cause. Enter Underl Cause (Disease or in that initiated events	lying njury	C										_		
	e exection and an and and and and and and and and	al Ex	resulting in death) L	ast	Due to	o (or as a cor	nsequence of):										
200	certificate be executed nding physician and use as the burial-transi	edical			d												
89	certific anding use as		IF FEMALE: 23b. Was decedent		23c. If yes, o		egnancy Fetal death 3	☐ Ectopic p	regnancy				230	d. Date of c		_	1
P.O. Box	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	in the past 12 n 1 Yes 2 2 9 Unknown			gnant at time		Other (spe						Month	Da	ay Year	
P.O.	that the	by Ph	Part II. Other signifi	cant condition	ns contributing to	death but no	ot resulting in the	underlying ca	ause giver	in Part I.		23e. Did to	bacco use	contribute	to the	cause of death?	?
	quires en sign	ted b	con	01 W	ry At	elen	oli-	sean			-)	1 🗆 Y	es 2 🗆	No 3 🗆	Probab	oly 4 Unkn	10WN
Records,	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for	Completed	(61	zest	ive he	an	Rail	wi	<i>?</i> 			24a. Was a autop perfor	sy med?	prior to death?	o comp	findings availabletion of cause	able of
E E	siclan: The law certificate has l	Be Co	25. Was case referre	ed to medical				<u>.,. </u>	26. Place	e of Death ((Check or	1 \(\sime\) Yes	2 18 No	1 L Y	/es 2		
Ĭ;	Physiclan: this certific ral director,	면 B		₹No			2 ER/Outpati					5 🗌 Resid			ecify)		
of r	ding Phy h. After thi funeral	ate:	27. Manner of Death 1 Natural	5 Pendir	g (Mo	e of injury onth, Day, Yea	ar) 28b. Time injury	of 28	3c. Injury a work? 1 □ ∨a	it es 2□No		d. Describe h	ow injury o	ccurred			
Division of Vital	al or Attend after death Director: /	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig 6 Could determ	not be 28e. Plac		At home, farm, s			.5 2011		f. Location (S	treet and N	lumber or F	Rural R	oute Number,	
Σ	ital or irs afte al Dire				bull	ding, etc. (Sp 					- 10	City or Tow					
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check 2	Medical F	Physician: To the xaminer: On the b Nurse Practition	asis of exami	nation and/or inve	estigation, in n	nv opinion.	death occu	irred at the	e time, date ai	nd place, ar	nd due to th	ne cause	e(s) and manner	stated.
	To the To the Comp	2	29b. Signature and t					29c.	License n	umber			29d. Date	signed (Mo	nth, Da		
			DVK)	MW Y			a : -		-	6012			(2	1191	11		
Ō	#1		30. Name and addre	ess of person	agathm	use of death	000 MI	tchel	11.11	e Ra	1#1	3-216	80.	di Cil	MO	2071	16
	Sta Registr		31. Date filed (Month	h, Day, Year) DEC 2 2	2011	Registrar's S	Signature	park	/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 918 M Stephen Cherv1 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany <u>Western Md. Reg. Medical Center</u> Cumberland 7. Age (In yrs. last birthday)
52 yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, 1 M 2 X 218-78-3122 Director ďĵ 1959 MD Usual Residence of Decedent show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 Valley St. Apt 4 21502 USA permit. Page 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) human resources education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 6 Daniel Lee Tasker Patricia Ann Dowsos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn Tasker-brother 14714 Rice Road, Hancock, MD 21750 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory 12/17/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ervice Licei 22. Name and Address of Facility David A. Burdock Funeral Home PA 21 N 2nd St, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any language immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) burial-t attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year Pregnant at time of death q 🗍 Unknown 9 Unknown Division of Vital Records, P.O. s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an After this certificate has I funeral director, page 2 s autopsy Yes 2 🗓 To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No Hospital ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) notion Kohen 161 2011 0067876 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) DEC 20

Manohar Chenchudalla, 12500 Willowbrook Rd, Cumberland, MD 21502

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month A Day Physician/ 2011 Jayne Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Gorman Calland Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 1.**X** M 2 □ F Min. Months Days Hours Director 214-28-6756 80 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No 0akland Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21550 3612 Gorman Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 1955 White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) f Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 construction construction worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Wesley Steyer Ada Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gorman Road, Oakland, MD 21550 Donald Wayne Steyer-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1. Burial 2 Cremation 3 Removal from State White Church Cemetery 12/17/2011 Oakland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home PA Signature of Funeral Service Licensee 21 N 2nd St, Oakland, MD 21550 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician weeks Subdural disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) EXAMINER To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi ARPROVED BY that initiated events Due to (or as a consequence of) resulting in death) Last CERTIFICATION Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident 5 Pending Fell down basement steps 1 Yes 2 No 12-64-2011 7:00 AM Investigation within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3612 (corman Rd. Ooklan Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12-16-2011 0047925 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Charles

31. Date filed (Month, Day, Year)

DEC 20

Fourth St. Oakland

311 North

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43065 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 26. 9:41 \mathbf{P}_{M} Sharon Joan Travis December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3201 Crest Avenue Prince George's Cheverly Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days (Month, Day December 1 🗆 M 2 🔀 F 527-58-1418 71 Director 1940 Prescott, Arizona Usual Residence of Decedent 28a-f shov Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Maryland Prince George's Cheverly 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a 20785 3201 Crest Avenue USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ò ģ 1 X Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 🛭 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working National Security and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agency Manager 5 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dorothy Sarah Day William Bliss Travis other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Carolyn Cornelius / Friend 3201 Crest Avenue, Cheverly, MD 20785 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/28/2011 Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Years Immediate Cause (Final Physician/ Metastatic Carcinoid disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or i that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No Month Year Pregnant at time of death 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No Yes 2 🛛 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗵 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) thin 24 hours a the Funeral C Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35996 12/27/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda Marie Burrell, M.D., 2730 University Blvd., Suite #400, Wheaton, MD 20902 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1530 M Craiq Randall Trautwein 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Garrett Co. Memorial Hospital Oakland Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F Months Maryland Days Hours Min. 6/6/1961 Director 213-82-4481 50 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d, Inside City Limits Director MD Garrett Oakland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 582 Hutton Road 21550 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes
If Yes, Give 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ${ t Automobile}$ Elementary/Seconday (0-12) College (1-4 or 5+) Parts Manager Dealership 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 0 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Charles George Trautwein, Jr. Beverly Ann McCarrier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dori M. Lewis/ Fiancee 582 Hutton RD., Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Countryside Crematory 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/22/11 Davidsville, PA. 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. 203 S. Second St., Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death tas Me Physician Eso Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Due to (or as a consequence of) cause. Enter Underlying and -transit Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1- Yes 2 No 3 Probably 4 Unknown Completed been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 Yes ᅌ Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. зГ only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D15333 12/18/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson 311 Fourth St., Oakland, MD 21550

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MICHAEL Month 12 Physician/ AIT Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Harwood Mandrin House If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Min (Month, Day, Year) **Director** 220-40-3911 1 XM 2 🗆 F 68 Yrs Jul. 25, 1943 or 28a-f show notified at 10a. State 10b. Count 10c. City, Town or Location Director Prince George's Bowie MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r Funeral U.S.A. 1508 Pernell Court 20716 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 ☐ No Navy If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after deat th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examine. Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Audio Engineer Broadcasting 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Barbara Ellen McLean Joseph X. Tait Department of Health and Important: If item 27 is many injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn S. Tait - Wife 1508 Pernell Court, Bowie, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place Metro Crematory 20a, Method of Disposition 20c. Location - City or Town, State Date Burial 2 XCremation 3 Removal from State 12-21-2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home Signature by Juneral Service Lice 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ CECTUM disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed certificate Yes MANDRININPI To the Hospital or Attending Physician: Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes No. 임 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending 1 Yes s after death 2 Accident
3 Suicide
4 Homicide Investigation Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of Gertifier 21438 oleted cause of death (Item 23a) (Type, 30. Name and address of person who con DEFENSE ITWY NNAPOLIS MOZIYO,

43067

3. Time of Death

0421

Birthplace (State or Foreign Country)

Washington DC

White

Approximate MONTHS

Year

Day

death?

10d. Inside City Limits

1X Yes 2 No

Year

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

DEC 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ${\tt December}^{\tt Month}$ 28,2011 Physician/ 1:45 AM James Preston Thomas Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 25525 Friendship School Road St. Mary's Mechanicsville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Days Hours March 31, Flordia 263-48-0867 Yrs. 1934 **Director** Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 🗌 Yes 2 🎇 No Maryland St. Mary's <u>Mechanicsville</u> 10e. Street and Numbe 10g Citizen of What Country? 25525 Friendship School Road 20659 USA items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White Completed 3 🗌 Widowed 4 🗌 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government Contractor Associate Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ James Preston Hardon Jessie Elizabeth Daughtry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20659 19a. Informant's Name/Relationship (Type, Print) Marlene B. Thomas (wife) 25525 Friendship School Road, Mechanicsville, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols 4 Donation 5 Other (Specify) 12/30/2011 Charlotte Hall, MD Signature uner Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Dea Immediate Cause (Final Physician/ Due to (o s a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or imput that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached f 1 Yes 2 L 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the t. 24 hours after death.
Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛎 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 XX 2 🗌 No 1 Yes 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 X No Other: 4 \(\sum \) Nursing Home 5 \(\overline{\Delta}\) Residence 6 \(\sum \) Other (Specify) Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred iniury 1 XVatural 5 Pending Accident 1 Yes 2 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one d title of certifier 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year, 142597 12-30-11

DHMH 17 Rev 7/2009

State

Registrar

H) ems

26840 Point Lookout Rd.

Leonardtown, MD

d address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey C. Brown, M.D.

31. Date filed (Month, Day, Year)

JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia Lee Tippett 2:05 P M December 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death <u>26315 Woodridge Drive</u> St. Mary's Mechanicsville If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdav) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Days 04/03/1948 Arlington, VA Director 577-66-2434 63 or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? Funeral 26315 Woodridge Drive 20659 IISA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic many. Elementary/Seconday (0-12) College (1-4 or 5+) <u>Staff Assistant</u> U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roy Edwin Lee Dorothy Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Guy Tippett, Sr./Husband 26315 Woodridge Drive, Mechanicsville, MD 20659 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Queen of Peace 01/03/2012 | Helen, Maryland . Signature of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. #M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 Part 1. Inter in disease, plications that caused shock, or he failure. List only one cause on each line plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ euleemic disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last ending physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live retail ueat
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 2 🗆 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending work? Accident
Suicide Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0055751

State Registrar Merchants Lanc Suite 205 Leona

who completed cause of death (Item 23a) (Type, Print)

40900

Schmidt

20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 31, 2011 9:46А. м Albert Ε. Tegeler Medical 4b. City, Town, or Location of Death Silver Spring 4c. County of Death
Prince George's 4a. Facility Name (if not institution, give street and number, **Examiner** 3154 Gracefield Road, HG#305 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days 92 Hours Ochent 22ay, 1919 Nevada 1 XM 2 □ F 517-16-3979 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Prince George's Silver Spring Maryland 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20904 3154 Gracefield Road, HG#305 be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Xyes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. 17 Yes, Give 1940-1945 Year or Date: If Yes. Give White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Electronics Engineer of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles George Tegeler Elizabeth Supp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4210 Harbour Town Drive Beltsville, Maryland 20705 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Charles J. Tegeler -son 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1/3/2012 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Bornald Wores Borg Wardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 50nsetand Death Immediate Cause (Final Congestive Heart Failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 10 years Coronary Artery Disease Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam Hospital or Attending Physician: The law requires that the death certificate be executed ttending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live Birth 2 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day 1 Yes 2 No the ed by t s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy funeral director, page 2 performed Yes 2 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) D24093 January 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Parkhurst, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

3 DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) 2 2012

			For State	State	of Maryla		rtment of	Health and N		0.0	2 1	10071	
			Registrar 1. Decedent's Name (First, Middle	e, Last)		Cer	incate or	Death	2. Date of De	Reg. No.] 	3. Time of Death	
P	hysicia Medic		Alber	ta W	hack				Decemb	erl ^{Day} ,	2011	5:18 A. M	
	Examin	er	4a. Facility Name (if not institution 36 Prairie Ro		mber)			or Location of Death hersburg			4c. County of Death Montgomery		
Fı	uneral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	9. Birth	place (State or Foreign	
	rector		214-82-3136	1 □ M 2 🕱 F	52	Yrs.	Months Days	Hours Min.	June 2	5,1959	Vir	ginia	
and	show	ō	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Loc	ation					10d. Inside City Limits	
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ith the	3a or t be n	ralD	10e. Street and Number	0			10f. Zip Code 208	70		10g. Citizen of Unite			
aath w	ems 2 er mus	Funeral Director	36 Prairie Ro	12. Was Dec	edent Ever in U		/as Decedent of I	Hispanic Origin? (Sp				can Indian,	
21215-0036 within 72 hours after degiene.	item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 X Never Married 2 Mar 3 Widowed 4 Divorced	If You Gir	2 🗶 No ve		Yes, specify Cub ☐ Yes 2X No	oan, Mexican, Puerto o Specify:	Rican, etc.)	Bla Specify	ck, White,		
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filed wall Hyg	d other	Be (17. Father's Name (First, Middle, I			[1.02.0	-6	18. Mother's Nam	e (First, Middle,		re)		
Yal uld be I Ment	narke natic e	P	Willie Thom			-		Sarah	Lee .	McClary	_		
Maryland 2 should be filed tth and Mental Hy	27 is r traun		19a. Informant's Name/Relations Zita Layta Go		ohter)			tand Number or Rur Street;Col					
			20a. Method of Disposition		20b.	Place of Dispos		1	Date 30,2011	20c. Location			
Baltimore, permit. Page 1 and Department of Hea	tant: l		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (\$	Specify)		verdale	Park C	rematory				aryland	
Bal permit Depar	Important: It any injury or once.		21. Sanatur of uneral Service	KB4	July	In	Name and Addr	ess of Facility ${f R}_ullet$ Kennedy St	N. Hort reet,N.	on Comp	any l	Morticians, on,D.C.20011	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on ea	caused the dea	ath. Do not ente	r the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
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6876 ertificate	ing phy as th	Med	IF FEMALE:										
Box 68 death certific	been signed by the attending pshould be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregn Birth 2 Fe gnant at time of	tal death 3	Ectopic pregnar Other (specify)	псу			ate of delivers	very Day Year	
the de	by the ached	hysi	1 Yes 2 X No 9 Unknown	9 🗆 Unk									
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cords,	peen s	Completed							24a. Was			obably 4 X Unknown opsy findings available	
Heco	has le 2	omp							auto perfo	psy ormed?	prior to co death?	ompletion of cause of	
VItal Records, sysician: The law requires	certificate rector, pag		25. Was case referred to medical examiner?	100			26. F	Place of Death (Chec		2 X No	i les	2 🗆 110	
Physic	this or ral dire	မ	1 Yes 2 X No 27, Manner of Death	Hospital: 1 28a. Date		ER/Outpatien	28c. Inju			dence 6 🗆 Oth		ý)	
on o	r: After e fune	icate	1 X Natural 5 ☐ Pendir 2 ☐ Accident Investi	ng (Mor	oth, Day, Year)	injury	wor	ry at ¹k? ☐ Yes 2 ☐ No	28d. Describe i	now injury occur	rea		
DIVISION OF tal or Attending Phrs after death.	n by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 28e. Place	e of Injury - At h	nome, farm, stre	et, factory, office		28f. Location (S City or Tov		er or Rura	al Route Number,	
DIVISION OF VITAL To the Hospital or Attending Physician: within 24 hours after death.	filled i		29a. Certifier 1 X Certifying	Physician: To the b	pest of my know	wledge, death o	ccured at the tim	e, date and place. a	nd due to the ca	use(s) and man	ner as stat	ed.	
he Ho	the Fur	Medical	(Check 2 Medical I		sis of examination	on and/or investi	gation, in my opin	ion, death occurred a	t the time, date a	and place, and du	ue to the ca	ause(s) and manner stated.	
To t	TO .	1000	29b. Signature and title of certifie	J. D.			29c. Licens			29d. Date signe			
	_		30. Name and address of person	who completed car	se of death (Ite	m 23a) (Type P		Wisconsin	Arronica	Decembe		28, 2011	
Ri	1		Nelson G. N.	Kalil; N	1.D.			wisconsing Chase, N					
R	Stat Registra		31. Dat DEC 2"9"2011	Beneva 32. F	Registra s Sign	and							

11-09687 Damon Washington

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 43072 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate of	Death			g. No.	
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Damon Norman Washington				2. Date of Deat Month December	Day Year	3. Time of Death 1310 hrs
		4a. Facility Name (if not institution, give street and number) Laurel Regional Hospital	14	b. City, Town, or Loc Laurel	ation of Death		4c. County of Dea	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	rs. last birthday) 31 Yrs.		f Under 24Hrs. Hours Min.	8. Date of Birt	1980 9. E	Birthplace (State or eign CountryWash DC
and show any ncs.	Ī	Usual Residence of Decedent 10a, State	City, Town or Locati New C	arrollton				10d. Inside City Limits 1 X Yes 2 No
with the Maryland 18 23a nr 28a-f sho e notified at once.	Director	10e. Street and Number 5305 85th Ave. #103		10f. Zip Code 20784	4	10	og. Citizen of What Co USA	ountry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ar items 23a nr 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 3 Widowed 4 Divorced (Yes, Give Yeer or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White 1 Yes 2 No specify: Specify:					ıck
36 nin 72 hours a. than "natur dical Exam	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+) 2	during me	's Usual Occupation ost of working life. DO houseman	(Give kind of w) NOT use retir	rork done red)	16b. Kind of Busines USDA	·
21215-0036 vald be filed within 7 Mental Hygiene. marked ather than ic event, the Medica	Be Com	17. Father's Name (First, Middle, Last) Norman Washington			Mother's Name		I Maiden Surname) rooks	
MD 21 d 2 should the and Mer th and Mer n 27 is mar numatic eve	5	19a. Informant's Name/Relationship (Type, Print) Sharon Brooks/ Mother	5305	85th Ave.	#103 N	ew Carr	ber, City or Town, Sta	20784
Baltimore, permit. Pages 1 an Department of Hea Impurtant: If iten		1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or oth Heritage	Mem. Cem.	1–3		Waldorf,	
	1	Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the de	10	583 Middle	eport L	n. Whit	lor II FH e Plains,	MD 20695
Physician Medical Examiner		23a. Part I. Enter the disease, or complications grat caused the deficiency failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	inshot Wound		ar as cardiac or	respiratory arre	sst, shock, or heart	Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the conditions).						
outed nd transit	I Examiner	(Disease or injury that initiated events resulting in death) Last d	ce of):					
760, icate be executed physician and the burial - transit	- h	UNPENDED AMENDED IF FEMALE: 23b. Was decedent preparation the	_				23d. Date of delive	· -
Box 687 e death certifi the attending ed for use as t	Physician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	- f - d	aldeath 3E	Ectopic pregna		Month	Day Year
s, P.O. nires that the signed by the detached	Ď	Part II. Other significant conditions contributing to death but r	not resulting in the u	nderlying cause giver	n in Part I.	1 Yes	2 ✓ No 3 Pi	to the cause of death? robably 4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Completed					24a. Was a autop perfor	sy prior to med? death	
Vital Relaysician: The this certificate	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2		3 DOA Oth	Death (Check o	g Home 5	Residence 6 Oth	ner:
ion of trending Pheath. ttm: After ty the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Manth, Day Year) Dec 22, 2010	28b. Time of Ir 1759 hrs	1 Yes	2 V No	Subject shot		
Division To the Hospital or Attent within 24 hours after death To the Funeral Directur:	Certification:	3 Suicide 6 Could not be determined (Specify) Hospital	ı			or Town, S 9136 Edmons	tate) ton Court, Greenbe	
To the Hospi within 24 hou To the Funer	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier			eath occurred a			the cause(s)
		and	Itom 23al	O.C.M.E			December 26,	
R2		30. Name and address of person who completed cause of death (Ana Rubio MD. Assistant Medical Examiner	900 W. Balti	more Street, Ba	lltimore, ME	21223		
St Regist	ate trar	31. Date filed (Month, Day Yan) 32. Registrar's light	natural					

43073

		-	For State	State of Ma	ıryland		artment of tificate of				giene —	OTT	7007
			Registrar 1. Decedent's Name (First, Middle, La	ist)			timodic o			2. Date of Dea	ath		3. Time of Death
	Physicia	n/	John David Whit							Month Decemb	er 22,	2011	10:25A M
	Medic Examin		4a. Facility Name (if not institution, giv	e street and number)			4b. City, Town	, or Locatio	n of Death			nty of Death	
			16100 Colwell Dri	lve					, Mar			nce Ge	
	Funeral		5. Social Security Number 6. S	7. Age		st birthday)	If Under 1 Ye Months Day		er 24 Hrs. Min.	8. Date of Birt (Month, Day 12/16/	h y, Year)	Cour	place (State or Foreign ntry)
-	Director		214-36-7883 Usual Residence of Decedent			70 Yrs.				12/16/	1941	Ohio	
	and show	ē	10a. State 10b. County		10c. City,	, Town or Lo	cation						10d. Inside City Limits
	Maryi 28a-f otifie	irec	MD Prince	George	Bran	dywin	e						1 🗌 Yes 2 ื No
	h the	Funeral Director	10e. Street and Number				10f. Zip Cod				10g. Citizen		ntry?
	th wit	ner	16100 Colwell I)rive 12. Was Decedent Ev	roy in II C	12.1	206	_	Origin? (Spe	cify Yes or No-		SA Race - Ameri	can Indian
'	er dea or ite niner	by Fu	11. Marital Status1 ☐ Never Married2 ☒ Married	Armed Forces?		1				cify Yes or No- Rican, etc.)		Black, White,	etc.
93	rsafte iral", Exar	ed b	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			☐ Yes 2 🛣	No Speci	ify:		Spec	cify: Wh:	ite
2-0	2 hou "natu edical	plet	15. Decedent's (Specify only highest g			(Give	lent's Usual Ockind of work do	ne during m	ost of worki	ng	16b. Kind o	f Business Ir	ndustry
12	thin 7 sne. than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5-	+)		O NOT use retir .ential		ceman		Gas Ut	ility	Company
0 0	ed wi Hygie other ent, tl	Be	17. Father's Name (First, Middle, Last,)		10010				e (First, Middle,	Maiden Sum	ame)	
lan	l be fil fental rked tic ev	입	James W. White					Vi	vian	M. Hami	1ton		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	ng Address (Stre	eet and Nun	nber or Rura	l Route Numbe	er, City or Tow	n, State, Zip	Code)
≥ ′	nd 2 sealth		David White / Son	1 <u> </u>	1			_		cketts		NJ 078	
ore	ge 1 and to the correct or other		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3		Ce	emetery, crer	sition (Name of natory or other	olace)		Date		,	
<u>ti</u>	iit. Pa artmer ortani injury		4 ☐ Donation 5 ☐ Other (Spec 21. Signature Funer Service Lice		Lou								Mary <u>land</u> eral Home,P.
Ba	permit Depar Impor any in		Martin CE	MOO	817								L, MD 20622
			23a-Part 1. Enter the disease, or conshock, or heart failure. List only	mplications that caused	the death								Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	Colon		er							Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a									
	Д жанно	ē	Sequentially list conditions,	b. Due to (or as a	consequ	ence of:						-	
	red nsit	mi	if any, leading to immediate cause. Enter Underl, in Cause (Disease or iinjury	540 10 (0) 40 0	. 00110044							-	
	execu in and ial-tra	EX	that initiated events resulting in death) Last	C. Due to (or as a	consequ	ence of):	-						
00	Attending Physician: The law requires that the death certificate be executed or death. ector: After this certificate has been signed by the attending physician and better. After this certificate based by the detached for use as the burial-transit by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical Examiner	•	d									
387	rtificar ling ph e as th	/Me	IF FEMALE:	23c. If yes, outcome	of progna	nov					7	D . () !	
Box 68760	ath ce attend for us	cian,	23b. Was decedent pregnant in the past 12 months?	1 Live Birth	2 🗌 Feta	ldeath 3	Ectopic pregi				230	Date of deli Month	Day Year
Ğ.	y the a	hysid	1 Yes 2 No 9 Unknown	9 Unknown									
P.O.	that the ned by a deta	by P	Part II. Other significant conditions	contributing to death be	ut not res	ulting in the	underlying caus	e given in P	art I.	23e. Did t	37		the cause of death?
ds,	requires been sig should b		1				<u> </u>			1 0			obably 4 Unknown
COL	has be	Completed								24a. Was	psy	4b. Were aut prior to death?	copsy findings available completion of cause of
Re	: The la	S									ormed? 2 No		2 🗆 No
ital	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:					Death (Chec	k only one) ome 5 KResi		Otl (C	
₹ 	Phys or this eral di	e: T o	27. Manner of Death	28a. Date of inju	ry	28b. Time o		njury at		28d, Describe			
ou c	ath. r: Afte	icat	1 X Natural 5 Pending 2 Accident Investigat		, rear)	injury		work? 1 🗀 Yes 2	2 □ No				
Division of Vital Records,	r Atte ter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine				reet, factory, off	ice		28f. Location (City or To		ımber or Rui	ral Route Number,
ă	oital o		29a. Certifier 1 Certifying Pl	nysician: To the best of	war lengual	ladaa daath	accurad at the	time data a	and place a	ad due to the c	ause(s) and m	anner as sta	ted.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exa	miner: On the basis of eaction wrse Practioner: To the	xamination	n and/or inves	stigation, in my c	pinion, deat	th occurred a	t the time, date	and place, and	d due to the o	cause(s) and manner stated.
	To the within To the comp	2	001 Circuture and title of contifier					ense numb			29d. Date si	gned (Month	n, Day, Year)
			n	skýgpaln	UVI.	1)	D005	7465			12	130/	1.1
	~ ~ ~ 10.		30. Name and address of person wh					002 7) _ 1	owo MT	1 2 1 2 2 2		
	5) RMG		N.S. Rajapakse,	M.D. 2835			., St#2	203, E	oaıt1M	ore, MI	, Z1ZU9		
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	Physicia	n/	1. Decedent's Name (First, Middle,				Death	2. Date of Death	Treate W	3. Time of Death 7:00 PM M
	Medic Examin	al	Judith 4a. Facility Name (if not institution,	give street and number)	Wilson	4b. City, Town, o	r Location of Death	Dec 2	4c. County of Dea	th
كمسي	Funeral		13 Beechwood 5. Social Security Number	6 Sex 7 An	e (In yrs. last birthday)	Cumb	If Under 24 Hrs.	8. Date of Birth	Allegan	tholago (State or Foreign
	Director		218-38-0429 Usual Residence of Decedent	1 M 2 K	69 Yrs.	Months Days	Hours Min.	Feb 16), 1942 °C	MD
	Maryland 28a-f show otified at	Director	10a. State 10b. County	egany	10c. City, Town or L	mberland				10d. Inside City Limits
	a or 28a be notif	al Dire	10e. Street and Number			10f. Zip Code	0.4500	1	0g. Citizen of What C	
	eath with	Funeral	201 Grand A	12. Was Decedent I	Ever in U.S. 13.	Was Decedent of H	21502 dispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Am	
980	s after de ral", or ite Examine		1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🔀 Divorced	Armed Forces? ed 1 Yes 2 If Yes, Give Year or Dates.		If Yes, specify Cuba 1 ☐ Yes 2 No		Rican, etc.)	Black, Whi	white
15-0	72 hours "natur iedical	Completed by		t's Education t grade completed)	(Give	edent's Usual Occup kind of work done OO NOT use retired)	during most of work	ing	16b. Kind of Business	Industry
212	within giene. Per thar t, the M		Elementary/Seconday (0-12)	College (1-4 or	D+)	care provi	der		self-emplo	yed
land	be filed lental Hy rked oth ic even	To Be	17. Father's Name (First, Middle, L Edward Jan	,			18. Mother's Nam Merian	e (First, Middle, M n Wilhelm		
, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at ance.		19a. Informant's Name/Relationsh Kathy Brode		ughter 1	ing Address (Street 3 Beechwo	and Number or Rur ood Drive	al Route Number, Cun	City or Town, State, Z nberland	MD 21502
Baltimore,	Page 1 an nent of He ant: If iten ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Xremation 4 ☐ Denation 5 ☐ Other (20b. Place of Disp cemetery, cre Scarpelli	osition (Name of ematory or other place uneral Hom	ne, P.A.	Date 12/28/2011	20c. Location - City o	
Balti	permit. Departr Importa any inju		21. Signature of Funeral Service L	ensee	2	22. Name and Addre 108 V	ieเก็ Funeral H /irginia Avenu	ome, PA e: Cumberla	and, MD 21502	
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that cause nly one cause on each in		ter the mode of dyir				Approximate Interval Between Onset and Death
	hysician/ Medical		disease or condition resulting in death)	_ a	a consequence of):	inter				
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence of):					
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09	ate be ex hysician he burial	I— I		d						
Box 68760	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 24 No 9 Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal death 3	☐ Ectopic pregnan ☐ Other (spec <i>ify</i>) _	су		23d. Date of d Month	elivery Day Year
ls, P.O.	uires that the n signed by ild be detacl		Part II. Other significant condition	ns contributing to death t	out not resulting in the	underlying cause gi	iven in Part I.			o the cause of death?
of Vital Records,	The law req ate has bee page 2 sho	Completed by						24a. Was ar autops perform 1 Yes	med? prior to death?	utopsy findings available completion of cause of
ital /	hysician; The la nis certificate ha: I director, page 2	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpati	_ Oth	Place of Death (Chec		Ohlow (Con	daughter's
of \	ing Phy fter this uneral d	ate: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	28a. Date of inju	iry 28b. Time	of 28c, Injur	ry at k?		w injury occurred	SHY/LEST METICE
Division	or Attendi after death Director: A in by the f	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 280 Place of Ini	ury - At home, farm, s c. (Specify)		Yes 2 No	28f. Location (St. City or Town	reet and Number or Fi n, State)	ural Route Number,
Δ	e Hospital 24 hours e Funeral	Medical	(Check 2 Medical E	Physician: To the best of kaminer: On the basis of a Nurse Practioner: To the	examination and/or inve	estigation, in my opini	ion, death occurred a	it the time, date an	d place, and due to the	e cause(s) and manner stated.
_	To the within To the comp	2	29b. Signature and title of certifier			29c. Licens	se number	1	29d. Date signed (Mor	th, Day, Year)
			30. Name and address of person of	who completed cause of c	leath (Item 23a) (Type,	Print)			12/27	
			Blanche May 31. Date filed (Month, Day, Year)	romatism	D. 12502	Willaubn	ook Rd. St	re.300 (1	umberlan	t, mo alsoa
	Sta Registra		16N	2 2012	ar's Signature	backer				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43075 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ Lois W. Adkins 30 1612 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** 4b. City, Town, or Location of Death REGIONAL CONICO Penidsula If Under 1 Year I If Under . Date of Birth 9. Birthplace (State or Foreign **Funeral** 222-12-7662 Days (Month, Day, Year) 7-24-1925 1 🗆 M 2 🖺 F Maryland Director 86 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Delaware Sussex Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19956 11135 Laurel Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Laurel School District Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Francis A. Woerner Mary Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26920 Kaye Rd. Laurel, De. 19956 Sue Hart (Daughter) 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Odd Fellows Cemetery | 12-27-2011 Laurel, Delaware 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 700 West Street Hannigan, Short, Disharoon F. H

23a. Part 1. Entertale disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hannigan, Short, Disharoon F.H. Laurel, De. 19956 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Cardingenio Shack minutes Medical resulting in death) Due to (or as a co quence of): Examiner ute covenas אסטכ Sequentially list conditions, cause. Enter Underlying Physician/Medical Examine Cause (Disease or injury that initiated events disco ovonan as the burial-trai resulting in death) Last Due to (or as a consequence of): attending physician Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death ed by the attendin detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death g Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed cardiomyopathi 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 🗌 Yes 2 🗌 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Investigation
6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗖 only one) 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 29c. License number mo DUITA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UTE

State Registrar STEPHAN

31. Date filed (Month,

SIADRE DR.

JALISBURY MO

400 E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1553 Marian L. Adkins 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death KENINSULA REGIONAL Medical 3ALB6414 HICOMICO If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 220-32-0395 **Director** 1 🗆 M 2 🕱 F 75 Jan. 1, 1936 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No MD Snow Hill Worcester 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 6607 Snow Hill Road 21863 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. the Medical Examiner Black, White, etc. þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced Specify white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dorothy French Marion Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Adkins (Husband) 6607 Snow Hill Road Snow Hill, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Dec. 23, 2011 Snow Hill, Maryland Bates Cemetery 21. Signature of Funeral Service Licensee Name and Address of Facility Short Funeral Home 13 E. Grove Street Delmar, DE 23a. Part 1. Leter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final SCVD Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Shoch Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner use as the burial-transi Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Day neral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached • Hospital or Attending Physician: The law requires that the 24 hours after death.
• Funeral Director: After this certificate has been signed by the properties of the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1. Diasua Mellitus type Division of Vital Records, 1 🗌 Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown Completed 2. Cushing 11 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to predica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 L Yes 2 No ည 1 Dinpatient 2 🗌 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

DHMH 17 Rev 06-2011

Registrar

the within To the 29a. Certifier

29b. Signature and title of ce

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REAN MOINUDDIN 1665 WOODBR

1665

3. Registrar's Signat

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0070129.

WOODBROOKE DRIVE, SALISBURY, MD 21804.

29d. Date signed (Month, Day, Year)

12/20/2011

29c. License number

PATRICK 11-09684 RAMON Unk Unk ALEXANDER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		I- For State Registrar		Certif	ficate of i	Death			eg. No.			
Physicia		Decedent's Name (First, Midd	le,Last)					2. Date of Dea		Vaar	3. Time of Dear	th
Medical Examir		PATRICK		ION	ALEXA	NDER		Month Decembe	Day r 25, 201	Year 1	1044 hrs	
		4a. Facility Name (if not institution			4k	o. City, Town, or Le	ocation of Dea			unty of Death		
		Prince George's Gene				Cheverly			Princ	ce George	's	1
				7 Ann (In In	hirthday	If Under 1 Year	If Under 24H	rs [8 Date of Bir			hplace (State or	=
Funeral		5. Social Security Number	6. S ex	7. Age (In yrs. last	ortriday)	Months Days	Hours M		a ((AUANDO))	Foreign	n	
Director		578-08-5310	1_xM 2_F	42	Yrs.	Morialo Bayo	1100.00	Jan.6	.196	9 Cou	^{intr} Wash.	.DC
		Usual Residence of Decedent	-10			<u> </u>						
kin	ı	10a. State 10b. County		10c. City, To	wn or Locatio	n					10d. Inside City	
_ & 3	.	D.C.			Wa	shingto	m			- 1	1 Yes 2	No
th the Maryland 23a or 28a-f show potified at once.	١ق	10e. Street and Number				10f. Zip Code	/11	11	Og Citizen	of What Coun	itry?	
Mary 28a	2	10e. Street and Number				Tot. Zip code		- 1				1
the tree	ة	4742 Benni	ng Road.	S.E. #	301		0019		Un		States	
with 52	Funeral Director	11. Marital Status	12. Was De	cedent Ever in U.S.	13. Was	Decedent of Hisp	anic Origin? (Specify Yes or No	14.	Race - Americ White, etc.	can Indian, Blac	ж,
ust if ath	١	1 Never Married 2 M	arried Armed F	orces?	If Yes	s, specify Cuban, I	Mexican, Puer	to Rican, etc.)		Wille, etc.		
r. er d		3 Widowed 4 Div	orced If Yes, Give Ye	ear X	1 ,	Yes 2 No	specify:		Spe	cify: B1	ack	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-fahe ent, the Medical Examiner must be potified at once	<u>a</u>	15. Decedent's Education (Spe	or Dates:			s Usual Occupation		f work done	16b. Kind	of Business/li		
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami	Completed	Elementary/Secondary (0-12)		1-4 or 5+)	during mos	st of working life. [DO NOT use re	etired)				
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Mer en e.	Ē.	12th				arehous		ne (First, Middle,		Priva	te	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	James Al	exander			Address (Street		Chlora	Alex	<u>ander</u>		
Med Med 22		19a. Informant's Name/Relations										
imore, MD 21215-003 Pages I and 2 should be filed within nent of Health and Mental Hygiene. Lant: Witen 27 is marked other th or other traumatic event, the Medi		Sharrnice Mc	Duffie/I	Daughter	4742	Bennin	g Rd.	,SE #30)1 W	ash.,	DC 200)19
Ore, N ges I and : of Health : Uitem : ther trau							etery,	Date	20c. Loca	ition - City or	Town, State	
= ° ≈ = s		1 Burial 2 Cremation	n 3 🗌 Removali	TOTT State	matory or othe							.
Pag Pag nent		4 Donation 5 Other S	pecify:	Har:	mony	Mem. Pa	rk 1	<u>-14-12</u>		<u>andov</u>	er. Mo	
Baltimo permit. Page Department Important: injury or ott		2 Signature of Funeral Service		10	22. Na	Mem. Pa	of Facility C	apitol	Mort	uary		
W 50 7 1 1		23a. Part I. Enter the disease, or	um- Ja	Llly	14	25 Mary	land	Ave1	VE W	ash.	DC 20	0002
Physician		23a. Part I. Enter the disease, or	complications that	caused the death. Do	o not enter the	e mode of dying, s	uch as cardiad	or respiratory an	est, shock,	or heart	Approximate Between On:	
(Medical)		failure. List only one cause	1-1	ral Hamberthaga							Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)		ral Herrforrhage a consequence of):	*							
	- 1	or condition rooding in dealing		ive Cardiovascu	ular Diseas	Se.						
	اچا	Sequentially list conditions, if any, leading to humoclate	-	a consequence of):	alai Diocal	30						
	<u>.</u>	cause. Enter Underlying Cause		e sonanquenno ora							1	
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):								
kecuted 1 and - transit	ă	events resulting in death) Last	d.									
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760, ficate be g physici the buri	ξ	IF FEMALE: 23b. Was decedent pregnant in t		, outcome of pregnar					23d. Da Moi	ate of delivery		еаг
Sox 687 death certifu e attending for use as t		past 12 months?		birth gnant at time of death			Ectobic bie8	illalicy	I	idi C	,ay	- I
Box 68 e death certil the attending ed for use as	S	1 Yes 2 No 9 Un	transver '=	nown	1 5 Oth	er (Specify)						
the de	Physicia				dina ia tha co	darbina enuen di	on in Part I	23e Did t	obacco use	contribute to	the cause of de	ath?
P.O. B s that the de med by the	Š	Part II. Other significant condi	tions contributing	to death but not resu	aiting in the ur	idenying cause gi	veri ili Fait i.				pably 4 🗹 Un	
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ם	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 El	R/Outpatient	3 DOA	Other Nur	sing Home 5	Residence	6 Other		
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ision of Attending Ph Attending Ph er death. ector: After t by the funeral	.5	1 V Natural 5 Per	ding	th, Day, rear)		1 Y	es 2 No					
ivisior or Attencather death Director:	g	2 Accident Inve	estigation 28e Pla	ace of Injury - At hom	e farm street	t factory office bu	ilding etc	28f Location	Street and I	Number or Ru	ral Route Numb	per, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuocral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	4 Homicide	(opcon)					4				
Hos 24 h Fuo stely		29a. Certifier 1 Certifying F	hysician: To the b	est of my knowledge,	, death occurr	ed at the time, dat	te and place, a	nd due to the cau	se(s) and m	anner as stat	ed.	
ithin mple	Medical	one) 2 Medical Ex	aminer: On the basis and manner	s of examination and	vor investigati	on, in my opinion,	death occurre	a at the time, date	and place,	and due to th	e cause(s)	
6,348	Me	29b. Signature and title of certif				29c. License	number		29d. Date	signed (Mo	nth, Day, Year)	
		(10.00	XLAON	d ik		O.C.N	Λ.E.		Decem	nber 26, 20	011	
_		care	irul	~ ~	2-1							
3		30. Name and address of perso		use of death (Item 23 I Examiner 90		imore Street	Baltimore	MD 21223				
							Jakinote,	1440				
	ate	31. Date filed (Month, Day, Year		Registrar's Signature	bar	0.1						
Regist	rar	JAN 17	2012 2	were a.	100	CC"						

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL OCME

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend 26 per med cert G924 272/12 dk

State of Maryland / Department of Health and Mental Hygiene 20 1 - State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ December 23, 2011 11:20 av Acevedo Aramis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casey House - Montgomery Hospice 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 5 Social Security Number **Funeral** Davs Hours Min. Country) Months 583-66-2215 1**X** M 2 □ F Director APR 8, 1955 Puerto Rico 56 Usual Residence of Decedent fshow 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location must be notified at Director 1 Yes 2 X No 28a-f Montgomery Village MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe or 23a Funeral United States 20886 20000 Hoffstead Lane items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Medical Examiner Armed Forces? Black, White, etc. o þ 1 Never Married 2 XMarried within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 No Specify: Caucasian Puerto Rican "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Carpenter - Supervisor Home Repairs other traumatic event. Be ermit. Page 1 and 2 should be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I ည Aidalina Perez Otilio Acevedo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 23550 Forest Haven Way, Clarksburg, MD 20871 Damaris Guiterrez / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date rtment of H rtant: If its njury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) All Souls Cemetery 12/30/2011 Germantown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ingrisee My 22 Name and Address of Facility
Thibadeau Mortuary Service, p.a. epe Impo M00956 Park Avenue, Gaithersburg, 23a. Parth. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Sue to fores a consequence of many, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialphysician a Physician/Medical DM€) P.O. Box 68760 as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 | Fetal deat Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Day Month Year Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bruchel Records, P page 2 should be ANOXIC BRAIN INJURY 1 Yes 2 No 3 Probably 4 Tunknown been 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? After this certificate has 1 Yes 2 No To the Hospital or Attending Physician: the funeral director, Vital 25. Was case referred to medical 26. Place of Death (Check only one) To Be Other: $_{4\,\square\,\,\text{Nursing Home}}$ 5 \square Residence 6 \times Other (Specify) hospice1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 23年五一0K Division of 28c. Injury at work?
1 Yes 2 No 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 24 hours after death. Funeral Director: Al Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar

DHMH 17 Rev 06-2011

10

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2

To the

DR. BINDU JOSEPH, M.D., 6001 MUNCASTER MILL ROAD, ROCKVILLE, MD 20855

29c. License number

D0060634

29d. Date signed (Month. Day, Year)

DECEMBER 23, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year) or othy OGUES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Burtonsville Sanctuary at Holy Cross If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year, Country)
New York. 1 M 21/2 F 073-24-9141 82 **Director** 1929 Usual Residence of Decedent 28a-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Funeral Director District of Columbia 1 X Yes 2 ☐ No Washington 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? 3900 16th Street, NW items 23a 20011 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Black "natural" Completed 3X Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) years Executiv<u>e Secretary</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herbert Johnson Lena McQueen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Bogues Leftwich/Daughter 3900 - 16th Street, NW Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place)
Leg's Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Dec 30, 201 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4001 Benning Road, NE Washington, DC 20019 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a the burial-t Completed by Physician/Medical P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown APNOET 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate hai death? 1 🗌 Yes Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide after death Director: / I in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) D 285 95 grelle. mrs)

Registrar

State

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SMITH

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

32. Regi

ASNEDM

3 2012

31. Date filed (Month,

JAN O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Leah R. Baumgardner 11:36 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2835 Roop Road Taneytown Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/11/191 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🗷 F 212-74-8283 Director 100 Taneytown. MI Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Taneytown 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2835 Roop Road 21787 USA 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Yes Yes Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene.
7 Is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Norman Reindollar Elsie Leister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 Is any injury or other trau Robert Baumgardner, JR.-Son 67 Rollins Dr. Palm Coast, FL 32137 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rinity Luth. Cem. 12/30/2011 Taneytown, 22. Name and Address of Facility Myers-Durboraw Funeral Hom 36 E. Baltimore St. Taneytown, MD 21787 Signature of Funeral Service Licensee ustin R. L 136 E. Baltimoré St. Taneytown, 2011. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final HOLLI CUCAR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year 1 L Yes 2 L 9 L Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending death. Investigation
6 Could not be 1 Yes 2 No within 24 hours after death

To the Funeral Director: A

completed filled in by the f Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Get High priyatroats. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print) lavio 31. Date filed (Month, Day, Year) State 2 8 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	larylan		artment of I tificate of I		and Mental H	ygien Reg. N	2011	4308
	Physicia	ın/	1. Decedent's Name (First, Midd	ile, Last)					2. Date of 1 12 26	Death		3. Time of Death
•	Medic Examin	cal	Henry Barth 4a. Facility Name (if not institution	on, give street and number)			4b. City, Town, o	or Location of			c. County of Death	8:00 AM
*			3200 Windrows				Eden	Lieuralia	MIL. 1		Vicomico	
	°Funeral Director		5. Social Security Number 103–24–8712	6. Sex 7. Ag	ge (In yrs. Ia	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 10 06	a 1:93(9. Birth Cour Au	place (State or Foreign htry) stria
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary 28a-f	irec	Maryland Wico	mico	Eder	n						1 🗌 Yes 2 ื No
	vith the	Funeral Director	10e. Street and Number 3200 Windrows				10f. Zip Code 21822			10g. C	Citizen of What Cou	ntry?
	death titems		11. Marital Status	12. Was Decedent Armed Forces?		i. 13. V		lispanic Origi	in? (Specify Yes or N Puerto Rican, etc.)		14. Race - Americ	
336	al", or	Completed by	1 ☐ Never Married 2 🛣 M 3 ☐ Widowed 4 ☐ Divorce	arried 1 Yes 2		st]	☐ Yes 2 🔀 No				Black, White, Specify: Wh:	
2-0	2 hours "natur edical	plete		ent's Education hest grade completed)		16a. Deced	ent's Usual Occup	pation during most	of working	16b.	Kind of Business In	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Elementary/Seconday (0-12)		5+)	Produ	O NOT use retired,)	or <i>tronning</i>	Fi.	lm	
, pue	e filed value Hyge ed othe event,	To Be	17. Father's Name (First, Middle					1	r's Name (First, Midd		n Surname)	
aryli	nould b nd Mei s mark umatic	-	Frederick Bart 19a. Informant's Name/Relation			19b. Mailin	a Address (Street	Elsa and Number	Unknown or Rural Route Num		or Town, State, Zip	Code)
	and 2 st Health a tem 27 is		Jeanette Barth	wife		3200	Windrows	Way,	Eden, Mar	ylan	d 21822	
nore	Page 1 annent of Hant: If ite		20a. Method of Disposition 1 ☐ Burial 2 🄀 Crematio 4 ☐ Donation 5 ☐ Other		, C6	emetery, cren	sition (Name of natory or other pla Cremato		Date 2 29 2011	1	Location - City or To Lisbury, I	
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signature of Funeral Service	1		HO	Name and Addre	ess of Facility	Home P.A			
	40200		23a. Part 1. Enter the disease,	or complications that cause	d the death				., Salisb ardiac or respiratory		Maryland	Approximate
	Ph _{sician} /	0.1	shock, or heart failure. Lis Immediate Cause (Final disease or condition	only one cause on each lin	eta	tic	Blaca	den	Can	es		Interval Between Onset and Death
Sagar	Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):						
		iner	Sequentially list conditions, if any, reaumy to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence ofj.					- 3	
	ecuted and -transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consecu	ence of):						
0	ate be executed physician and the burial-transit	edical		d								
68760	irtificate ling phy e as th		IF FEMALE:	220 If yes, cuteems	of progner	201						
Box (Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 Fetal	death 3	Ectopic pregnan Other (specify)	су			23d. Date of deliv Month	ery Day Year
P.O.	ires that the dea signed by the a		g Unknown Part II. Other significant condi	9 Unknown	but not resu	ulting in the u	nderlying cause g	iven in Part I.	23e Did	Itobacco	use contribute to t	he cause of death?
	luires the	ed by		_						Yes 2	V'	bably 4 🗌 Unknown
COL	law require has been si e 2 should	Completed								opsy	prior to co	psy findings available impletion of cause of
I Re	sician; The law certificate has k lirector, page 2 s		25. Was case referred to medica	1			26 P	lace of Death	1 Ye	formed?	death?	2 No
Vita	hysicia his cert I direct	To Be	examiner? 1 Yes No	Hospital:	-	ER/Outpatien	lott	er.	rsing Home 5	sidence	6 ☐ Other (Specify	·)
n of	ding P th. After t	cate:	27. Manner of Death Natural 5 Pend 2 Accident Inves	28a. Date of injuding (Month, Date of injuding)	ury ay, Year)	28b. Time of injury	28c. Injur wor M 1 \square		28d. Describe	e how inju	iry occurred	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Certificate:	3 🔲 Suicide 6 🗀 Coul	d not be			et, factory, office	100 1 1	28f. Location	(Street a.	nd Number or Rura e)	Route Number,
۵	spital cours at neral D		29a. Certifier Certifyii	ng Physician: To the best of	f my knowle	edge, death o	ccured at the time	e, date and p				ed.
	To the Hospital within 24 hours a To the Funeral Completed filled	Medical	(Check 2 Medical only one) 3 Certifyii	Examiner: On the basis of eng Nurse Practioner: To the	examination	and/or invest	igation, in my opini	on, death occ	curred at the time, date	and plac	e, and due to the ca	use(s) and manner stated
	To with		29b Signature and title of certification	ell	1	W	29c. Licens	e number	278	29d. D	ate signed (Month,	Day, Year)
•	TO		30. Name and address of perso	who completed cause of	death (Item)	23a) (Type, P	rint) Dr. Or	11/17	27 011	100	1011	> 106)
	Stat	te	31. Date filed (Month, Day, Year)	2011 32. Fegistr	LHC ar's Signati	Jreg J	PU 190	XIT	55 SH4	ISBL	ery, pu	741801
H	Registra		UEC 2	9 2011 Jane	un ,	p. 19	ander					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 1836 Margaret 2011 Medical 4a. Facility Name (if not institution, give street and number) **E**xaminer 4b. City, Town, or Location of Death 4c. County of Death WICOMICO Salisbury Genes If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months 9 Hours Min. (Month, Day **Director** Gaithersburg, MD Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 28a-f 1 Yes 2 X No Maryland Worcester Berlin 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1135 Ocean Parkway, Bldg. B, Unit 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married Yes 2 No 1 Yes 2 X No Specify: Baltimore, Maryland 21215-003 If Yes, Give 3 Widowed 4 Divorced Specify: White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be George Reber Edna Henneberger Important: If item 27 is mark any injury or other traumation 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James White/Son 10845 Bellerive Lane, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Salisbury Crematory 1/2 2012 4 Donation 5 Other (Specify) Salisbury, MD 21. Signature of Funeral Seprice Licensee ² Namand Address of Facility HOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CESX 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ tage disease or condition resulting in death) Tud Medical Due to (or as a con equence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à page 2 should be 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer Yes 2 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes Investigation 6 Could not be 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

(Molay

Margaret

260

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signati

29d. Date signed (Month, Day, Year)

Civic Ave Salisbury, Md 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 24a, 25, 26&27 per med cert G923 1719/12 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Yea Physician/ BENNETT 0731 24 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SALISBURY MI WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, Days Months Hours 97 Yrs 124166196 ۷ă Director 4/12 Usual Residence of Decedent shov 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State aţ Director ms 23a or 28a-f s must be notified 1 X Yes 2 No Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Times Square 21801 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes X☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: sparkack 3 X Widowed 4 □ Divorced Year or Dates item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Salon Owner Self-Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Unk Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 113, Mappsville, VA 23407 Nina Teague/God-daughter PO. Department of Healt Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other []ataC 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial ② Cremation 3 ☐ Removal from State Cremation, 1-2-2012 4 ☐ Donation 5 ☐ Other (Specify) Dover, DE 21. Signature of Funeral Privice Licenses Bennie Smith W. Isabella St. Funeral Home Salisbury, MD 21801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to or a **Examiner** Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Box (3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown Ö signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No Physician: The law certificate 1 ☐ Yes 2 ☐ No director, Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 🗷 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Division Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature MD. D 0071972 son who completed cause of death (Item 23a) (Type, Print) SHAIK S. DIVISION ST MD-21804 AM EER ABDUL 1415

State Registrar 31 Date filed (Month.

Year)

03

32. Redistrar's Signature

			Please ⁻	Type or Print in Black Amend 24a per med State of Maryland / De	Indelible In	k.15psyre	Copies A	re Legible.	
	•	•	For State Registrar		epartment of F Certificate of L		/iental Hygier Reg. l	4011	43084
i	Physicia Medic		1. Decedent's Name (First, Middle Last)	Burleson J	Σr.			Day O'4 Year	3. Time of Death
Sec.	Examin		4a. Facility Name (if not institution, give s: Prince George	e Hospital	Cheve	r Location of Death	3	County of Death	George
	Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 1 Visual Residence of Decedent	7. Alge (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year		nplace (State or Forlign ntry)
	ryland I-f show ied at	Director	10a. State 10b. County	10c. City, Town o	or Location		, , ,		10d. Inside City Limits 1 ★ Yes 2 □ No
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. item 27 is marked other than "Hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		10e. Street and Number	INCUP	10f. Zip Code	>	10g.	Citizen of What Cou	•
	leath wil items 2: er musi	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
9036	rs after d ıral", or i I Examin	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates. 1944 - 1946	1 Yes 2 No		nicall, etc.)	Black, White	etc.
21215-0036	i 72 hou an "natı Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed)	ecedent's Usual Occup Give kind of work done of e. DO NOT use retired)	during most of work	ing 16b.	. Kind of Business/li	
	ed within Hygiene. Ither than	Be Co	17. Father's Name (First, Middle, Last)	College (1-4 or 5+) ""	Brick Ma	SON 18 Mathar's Nam	e (First, Middle, Maide	Constru	iction
Maryland	uld be filed Mental Hy narked oth	Tol	William Roy	Burleson Sr				aman	
, Mar	d 2 shou salth and n 27 is m er traum	74	19a. Informant's Name/Relationship yp	e, Print) 196. N 196. N 500 Wife 5	Mailing Address (Street	and Number or Rura		Town, State, Zip	VA 23601
nore	e	al control of	20a. Method of Disposition 1 ☐ Burial 2 📈 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State cemetery,	Disposition (Name of crematory or other place	ce)	7	Location - City or	Town, State
Baltimore	permit. Pag Department Important: any injury c once.		21. Sign true of Funeral Septic License	Mamptor	22. Name and Addres	1	10 Harper	Svile Ra	Newport New
	20260		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused the death. Do not	enter the mode of dying	ng, such as cardiac	or respiratory arrest,	1	Approximate Interval Between
phone	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Due o (or as a consequence of)	suc to	raython	W		Onset and Death
	Examiner	er	So us mistly list conditions if any, leading to immediate	Due to (or as a consequence of	An terry	disex:	se_		
	executed an and irial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	End STA	ge ren	A 1	setse		
90	E a e		resulting in death) Last	Due to (or as a consequence of	<u> </u>				
(687	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medical	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death	3 ☐ Ectopic pregnand	P.V.		23d. Date of deli	very
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s, P.Ö	res that t signed b	by	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given	ven in Part I.			the cause of death?
cord	aw requi as been 2 shoul	Completed					24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
I Re	sician: The law recrificate has the director, page 2 s		25. Was case referred to medical			lace of Death (Check	performed?	? death?	2 🗆 No
Vita	Physicia this cert ral direct	To Be	examiner? 1 ☐ Yes 2 🕱 No	ospital: 1	atient 3 DOA Oth	er:	ome 5 Residence	6 ☐ Other (Special	(y)
on of	ath. r: After t	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Tin inju	iry work		28d. Describe how inj	jury occurred	
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the time the completely filled in by the funeral director, page 2 should be detached for use as the but the completely filled in by the funeral director.		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		28f. Location (Street a City or Town, Sta		al Route Number,
	ne Hospita in 24 hours ne Funeral pletely filled	Medical	(Check 2 Medical Examine	cian: To the best of my knowledge, de er: On the basis of examination and/or in Practitioner: To the best of my knowle	nvestigation, in my opinio	on, death occurred at	the time, date and pla	ace, and due to the c	ause(s) and manner stated.
	To the P within 24 To the F complet	-	29b. Signature an Mite of certifier	Tun X V	29c. License			Date signed (Month,	
			30 Name and address of person who co	polete Cause of death (Item 23a) (Ty	pe/Print) Driv	e Ches	exty li	2078	1 5, 2011
	Stat Registra		31. Date filed (Month, Da) AN 17	20 232. Resistrar's Signature	parker	0,00	. ,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of State	Maryland / Depa			al Hygiene	2011	43085
			Registrar	Cei	rtificate of Dea		Reg. No.	2011	3. Time of Death
C	Physicia	an	Decedent's Name (First, Middle, Last) DATE: 1. Decedent's Name (First, Middle, Last)	7		IV	onth Day cember 18	Year	5:50 P M
	/Medic		PATTY J. BLACE 4a. Facility Name (If not institution, give street and numb		4b. City, Town, or Loca			County of Deat	
	Examin	er			Crisfi				Somerset
	Funeral			Age (In yrs. last birthday)	if Under 1 Year If U	nder 24 Hrs. 8. D	ate of Birth Month, Day, Year)	9. Birt	hplace (State or Foreign
L	Director		269–44–9834 ^{1□ M 2} XF	64 Yrs.	Months Days No	Ju	ne 27, 1	947 Mis	sissippi
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	//anyla	ō				iald			1 TYYes 2 □ No
	the A	Director	Maryland Somerset 10e. Street and Number		Crisf	тета	10g. Cit	izen of What Co	ountry?
	3a or st be		22 W. Main Street		Cri	sfield		USA	
	death	Funeral	11. Marital Status 12. Was Deced	ent Ever in U.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me	ic Origin? (Specify)	Yes or No-	14. Race - Ame Black, White	
9	or Ite		1 Married 2 Married 1 ☐ Yes 2	⋈ No	1 □ Yes 2X No Sp				White
21215-0036	be filed within 72 hours after death with the Maryland Hylgiene. do ther than "natural", or items 23a or 28a-f show do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Date		dent's Usual Occupation		16h K	ind of Business/	/Industry
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7	with jene. r thar the N	E I	Elementary/Secondary (0-12) College (1-4		eafood Worke	er	S	eafood_	Manufacturer
	e filed vall Hygie other I	Be C	17. Father's Name (First, Middle, Last)			Mother's Name (Firs	st, Middle, Maiden	Surname)	
/lar		To E	Elmer James Black			Sue Jean	Martin	,	
Maryland			19a. Informant's Name/Relationship (Type. Print) Ronald Black (Brother)		ng Address <i>(Street and N</i> V. Main Stre				
	Health tem 27 other tra		20a. Method of Disposition	20b. Place of Dispo		Date		ocation - City or	
Baltimore,	Pages nent of int: If its iny or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)		ge Mem. Park	12/22/20)11 Cris	field,	Maryland
a E	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	/ }	2. Name and Address of				
<u> </u>	lm an		Mary Beth Bradshaw-Pru		306 W. Main			MD 2181	7
μ			23a. Part1. Enter the disease, or complications that car shock, or heart failure. List only one cause on each	used the death. Do not en ch line.	ter the mode of dying, su	ch as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
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ŕ	/Medical Examiner		resulting in death) Due to (o	r as a consequence of):				3	
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8760,	ate be ex nysician he burial	ical	d		-				
39	ertifice ing ph	Med	IF FEMALE:						
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0	he de the a	Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown		Other (specify)				
Ω.	res that the de igned by the a be detached I		Part II. Other significant conditions contributing to dea	th but not resulting in the u	anderlying cause given in	Part i.	23e. Did tobacco	use contribute t	o the cause of death?
Records,	quires n sign ild be	d by					1 ☐ Yes 2		robably 4 ☐Unknown
000	s been si should	Completed					24a. Was an	24b. Were a	utopsy findings available
	The law ate has page 2:	шо					autopsy performed? 1☐ Yes 2☐ No	death?	completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?		26.	Place of Death Ch			
or V	dis di	은	1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ In	patient 2 ER/Outpatie		Nursing Home			ecify)
ū	ding Ph .r After th funeral		T Litardian C Literian	f Injury 28b. Time of 28b. Time of Injury	Work?		Describe how inju	ry occurred	
isio	or Attending after death. Director; After in by the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of	of injury - At home, farm, st	M 1 ☐ Yes		ocation /Street a	nd Number or F	Rural Route Number,
Division		Certification:	4 Homicide determined building	g, etc. (Specify)	,		City or Town, Stat		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	alc	29a. Certifier (Check only 2 Medical Examiner: On the ba						
	To the He within 24 To the Fe complete	ledical	one) and manne						
	To the within To the	Σ	29b. Signature and title of certifier	\sim	29c. License nur	COSIT	29d. Da	ate signed (Mon	om, Day rear)
E1	(4)		20 Name and address of seven into completed	of death (from 22a) /T:	Print) W-1	<u> </u>		011	(' / /
	5		30. Name and address of person who completed cause	Call was	Chis A	kins M.I	in -	2180	2
	Sta	ate	31. Date filed (Month, Day, Year) 32. Re	giatrar's Signature					
	Registi	rar	DEC 2 0 2011	eneva B.	gan				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ide11 McClintock Brown December 2011 2045 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Brooke Grove Rehabilitation and Nursing Cente Montgomery Sandy Spring If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) A 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 1 □ M 2 □XF Hours March 18, 1921 Director 186-16-8741 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director MD Montgomery 01ney 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3528 Falling Green Road 20832 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Z No Specify: 3 ☐Widowed 4 ☐ Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public School System Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lee Ellsworth McClintock Freda Weiskerger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3528 Falling Green Road, Olney, MD 20832 Susan B. Marchone/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Parklawn Memorial Park Dec 30 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spri .MD 20901 Silver Spring 23a. Part 1. Inter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Inter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Altheimers 18acs disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause E. ter Underful, y Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exam or Attending Physician: The law requires that the death certificate be executed sician and burial Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death been signed by the should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 2 🗎 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Μ Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 27, 2011

State Registrar un

28 2011

31. Date filed (Month, Day, Year)

DEC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GraceBrocke Huffman, MD 18100 Slade School Kood Sandy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Morris Edward Cotton, Jr. 1:35 AM 12 2 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner wi canico Coastal Hospice Salisbur The If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Hours Min. (Month, Day, Year) -25-1959 Country) 1 X M 2 🗆 F **Director** 212-72-2120 MD Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 as or 28a-f shov Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X☐ No Westover MD Somerset 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21871 USA 8193 River Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give SpeciBlack 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 nand Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Perdue 12 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Morris E. Cotton, Sr. Deloris Armwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice Cotton/Brother 29922 Fairmount Rd, Westover, MD 21871 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2-31-2011 Westover, MD Macedonia UM Cem 21 Signature of Fulleral Service Licensee 22. Name and Address of Facility rell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Hetastaka Cálo Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events and burial-trar Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Host ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Call Certificate: Natural 5 Pending 1 🗌 Yes Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 631 99 23/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OGESTA VOHRA SALISBURY 910 CASTERN SHORE DA 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month # Physician/ Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Living Well Assisted Living Millersville MD If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 164-36-6245 **Funeral** Months Days Hours Min 9/23/15 **Director** 1 M 2XXF PA Yrs. 96 show 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director MD Anne Arundell Millersville MD 1 Yes 2 X No 10e. Street and Number 271 Pasadena Rd 10g. Citizen of What Country? 10f. Zip Code Funeral 21108 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 9 þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White Completed 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last)
Louis D. Quinio, Sr. 18. Mother's Name (First, Middle, Maiden Sumame) D. 2 Julia Gubiotti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John / Son Canterna 336 Double Eagle Drive, Linthicum MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State st. Mary's Cemetery 1 Burial 2 Cremation 3 X Removal from State 1/4/12 PA 4 Donation 5 Other (Specify) Freeport, of Funeral Service Licensee Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 VIV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ongustive disease or condition Medical resulting in death) Due to (or is a consequence of): **Examiner** LMIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Pregnant at time of death detached been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe 1 Yes this certificate 2 🗌 No Yes 2 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number DO DU 4471 ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

Year,

32. Registrar's Signature

Amold MD 21012

1-09780	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
latthew Levi Cooks	1. For State Contificate of Death	011 4308
Physician/	Registrar 1 Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death
Medical Examiner	Matthew Levi Cookson December 29, 2011	0033 HIS
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County Wicomit	
	9544 Ocean righway #100	
Funeral Director	Months Days Hours Min.	Foreign Coudermany
Birector	445-68-8396 1 X M 2 F 40 Yrs.	Germany
any .	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
and show	Maryland Wicomico Salisbury	1 Yes 2 X No
hours after death with the Maryland traitural", or items 23a or 28a-f show Examiner must be notified at soce.	10e. Street and Number 10f. Zip Code 10g. Citizen of W 27028 Barrington Ridge Drive 21801 USA	nat Country?
th the 23a or 10 left		e - American Indian, Black,
r death with or items 23 must be no Funeral	11. Marital Status 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Racc Whit	e, etc.
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5-0036 led within 72 hours at tygene. other than "natural the Medical Examin Completed by	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	<u> </u>
215- be filed and Hy rked of cot, the	Tommy Wayne Cookson Suzanne Lider	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " injury or other traumatic event, the Medical TO Be Complet	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow	
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ore, ss l an of Hea If itel	1 Burial 2 X Cremation 3 Removal from State crematory or other place)	•
LimC Page ment taot:		bury, MD
Balt permit Depart Impor	21 Signature of Funeral Service Licensee 22 Name and Address of Facility Holloway Funeral Home Profession 501 Snow Hill Rd., Salisbury, MD	al Association 21804
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he	eart Approximate Interval Between Onset and
/Medical.	failure. List only one cause on each line. Immediate Cause (Final disease a Asphyxia	Death
Examiner	or condition resulting in death) Due to (or as a consequence of):	
- d	Sequentially list conditions, if any, leading to immediate b. Inhalation of Helium Gas Due to (or as a consequence of):	
	Course Enter Underlying Course C. (Disease or injury that initiated	
ecuted and - transit	events resulting in death) Last Due to (or as a consequence of):	
8 F-1 S	T INDENDED	
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteodiog Physiciae: The law requires that the death certificate be exwithin 24 hours after death. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the bunial configuration. To Re Completed by Physician/Medical Certification:	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of	
687 certific nding se as ti	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 5 Other (Specify)	Day Year
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o. E at the the stached		tribute to the cause of death?
ires th		Probably 4 Unknown Were autopsy findings available
w requests been should	24a. Was an 24b. autopsy performed?	prior to completion of cause of death?
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certify ector,	25. Was case referred to medical	Othor: Scana
Physic ral dir.	O 1 ✓ Yes 2 No 128e Detect Injury 28b Time of Injury 128c Injury at Work? 28d Describe how injury occur	
odiog diog	27. Manner of Death 1 Natural 5 Pending 20a. Date of Injuly FOUND: 1 Yes 2 No Subject purposefully inl	naled helium gas
isio Attector by th	2 Accident Investigation Dec 29, 2011 0024 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Num or Town, State)	ber or Rural Route Number, City
Div ital or Ital Div Illed in	Natural 5 Pending Investigation 28 Packet Pound Province	, Delmar, MD
Division of Vital Records, P.O. B To the Hospiral or Atteodiog Physiciae: The law requires that the dawinin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached completely filled in by the funeral director, page 2 should be detached to provide a second page 2 should be detached by Physician Contribution: To Re Completed by Physician Contribution and page 2 should be detached by Physician Contribution.	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mann (Check only)	er as stated.
To the within To the comple	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.	gned (Month, Day, Year)
•	Signature and rule of certifier	er 29, 2011
	U	
3TO1	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Stat	31 Date filed (Month, Day Year) 32 Registrar's Signature	
Registra	13 (3) 11 (3) (11 (4) (4) (4) (4) (4) (4) (4)	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 21 per DVR G923 1/19/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 43090 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:15 P M 2011 Linda J. Culver Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 172 Old Zion Road, Apt. A North East Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 169-44-2564 58 1 M 2X F 2/4/1953 PΑ show an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Cecil North East 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 172 Old Zion Road, Apt A 21901 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ntal Hygiene. ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ည Mary Bell Bernard Shaw traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 172 Old Zion Road, Apt. A, North East MD 21901 f Health item 27 William Culver - husband other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o once. 1 Burial 2X Cremation 3 Removal from State Rising Sun, MD RT Foard Funeral Home 12/15/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RT Foard Funeral Home, PA 21. Signature of Funeral Service Licensee Frank McFadden per DVR 111 S Queen St., Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Hepatitis C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transi Diabetes Due to (or as a consequence of): Physician/Medical the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 L retail 300.
Pregnant at time of death in the past 12 months? Day Month signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, infected knee prosthesis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? eral Director; After this certificate I filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛣 No Other: မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA e Hospital or Attending Ph 124 hours after death. e Funeral Director; After th Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical To the Hosp within 24 hou To the Funer completely fi 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 01/04/2012 H0071029 Do 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Steven Brestow DO, 111 West High Street, Suite 314, Elkton MD 21921 31. Date filed (Month. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 4309 Certificate of Death 1. Decedent's Name (First, Middle, Last)

Myroslawa 2. Date of Death 3. Time of Death Month 12/31 / 2011 Maria Capp Physician/ $1:50pm^{M}$ Medical 4c. County of Deeth imore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Examiner** Nursing Home Milford Manor Social Security Number 203–26–1032 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth **Funeral** 3711/21 ^{Coun}Ukraine 90 1 🗆 M 2 🕇 F **Director** show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Baltimore Baltimore MD 28a-f XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or items 29a or in jury or other traumatic event, the Medical Examiner must be a one. 21209-1067 by Funeral 2 Houndswood Ct USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 XX Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Medical Pharmacy Pharmacist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anton Duchnycz Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Houndswood Ct Baltimore MD 21209-10 Andrew Surmak 21209-1067 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗌 Burial 2 🗆 Cremation 3 🔀 Removal from State Woodlawn Cemetery 1/5/2012 Detroit, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EUMONITIS Physician/ FN disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MONTHS STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VALVULAR Records. 2 1 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No DEMEN TIA 24a. Was an Was a autopsy performed has completely filled in by the funeral director, page 2 within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☑ No ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 1 Natural Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 06-2011

2 HOUNDSWOOD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	tate of Maryl		artment of F rtificate of			ene g. No. 20	1 43092
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medi		CARMINE CHAR	LES COI	RO			Decembe		
-	Examir		4a. Facility Name (If not institution, give street	et and number)		4b. City, Town, o	r Location of Death	the -	4c. County of De	eath
н			7733 River Road			Westov			Somerse	et
	Funeral	П	Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	Birthplace (State or Foreign Country)
	Director		100-30-9367	72	Yrs.			04/30/1	939 N∈	w York
	M.		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or La	cation				10d. Inside City Limits
	f show	5	Maryland Somerset		7.	estover				1 □Yes 2 No
	the N	Director	10e. Street and Number		V'	10f. Zip Code		10	g. Citizen of What	Country?
	with sa or					,	21871		U.S.A.	
	ns 2:	Funeral	7733 River Road 11. Marital Status 12. V	Was Decedent Ever i	in U.S. 13.1	Nas Decedent of H	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		merican Indian,
က	riter of			Armed Forces? IXIYes 2 □ No 1 fYes, Give	1956_			Rican, etc.)	Black, W	
03	al", o	þ	3 ☐ Widowed 4 ☐ Divorced	fYes, Give /ear or Dates:	1960	1∐Yes 2M∏No	Specify:		Specify: V	nite
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show digal Exeminar is ust be notified at	Completed	15. Decedent's Education (Specify only highest grade control	n mpleted)	16a. Dece	dent's Usual Occup	ation during most of work		6b. Kind of Busine	ss/Industry
7	within iene. than "	npjdu		College (1-4or 5+)	life.	DO NOT use retired	d)	9	_3 ,	
	filed within Hygiene. other than "	S	7		Car	otain	40 Mathada Nasa	e (First, Middle, N	Charter	Boat
ī	ould be filed w Mental Hygie larked other t latic event, th	Be	17. Father's Name (First, Middle, Last)						iaiden Surname)	
S	should and Mer s marke umatic	မ	Carmine Charles Coin				Helen E		0" - T - 01-1	7:0:40
Maryland	12 shouth and No. 7 Is mai		19a. Informant's Name/Relationship (Type. In Deborah Anne Coiro	*		•	oad - Wes		City or Town, State	e, Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination of the Item and Item and Item at the modified at		20a. Method of Disposition	, ,					20c. Location - City	or Town, State
Baltimore,	00		1 ☐ Burial 2 🔯 Cremation 3 ☐ Remo	oval from State		sition (Name of natory or other place	i	10000		
Ī	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses			of Delm 2. Name and Addre		16/2011	Delmar,	DE
Ba	permit. Departr Importa any inju		Illa 184115	Inf	Br	radshaw &	Sons Fur			,
			Robert H. Bradsha 23a. Part 1. Enter the disease, or complication						_MD_21817 est,	Approximate
	Dharistan		shock, or heart failure. List only one ca Immediate Cause (Final	ause on each line.	-	33		, ,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a con	e Fa	illeti C				-/wh
7	Examiner			210	Labolat	Meel	growt M	to lange	Mass	4 6 mall
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	The second of th		-			
	cutec nd ransit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	e exe	m	resulting in death) Last	Due to (or as a con	sequence of):					
8760,	icate be executed physician and the burial-transit	dical	d							
Ψ		Mec	IF FEMALE:	.77				-		
Вох	eath certifi attending I for use as	ian/	in the past 12 months?	f yes, outcome of pro 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnanc	су		23d. Date of Month	delivery Day Year
0	at the de by the a	Physician/Me	1 TVas 2 TNo	4 □ Pregnant at time 9 □ Unknown	of death 5L	Other (specify) _				
σ.	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions contribu	uting to death but not	t resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
of Vital Records,	sign d be	d by	Ingula De	render of Y): celsale			1 □ Ye	s 2 No 3	Probably 4 Unknown
Ö	w requir s been s should	Completed	1	A = D.	eare			24a. Was ar	24b Were	autopsy findings available
Re	he law e has ge 2 s	Ē	Coveries 14	7	CALE			autops	y prior ned? death	to completion of cause of
ā	sician: The la certificate ha rector, page 3		25. Was case referred to medical	e_			Of Place of Dec	1 ☐ Yes th (Check only one		∕es 2□No
5	Physician: r this certific ral director, I	Be C	examiner?	ital:	2 D ER/Outpatier	oth 3 D DOA Oth	or:	•	nce 6 ☐ Other (5	Pagailty)
	ding Phys h. After this funeral di	으	27. Manne of Death	8a. Date of Injury	28b. Time o	28c. Inju	ry at	28d. Describe ho	·	эрөспуу
<u></u>	Attending it death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Yea	(r) Injury	M 1 🗆	k?]Yes 2 □ No			
Division	er des recto by th	Ę	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	8e. Place of Injury - A	At home, farm, str	eet, factory, office	3,00	28f. Location (St. City or Town	reet and Number of	Rural Route Number,
Ö	tal or rs afte al Dir ed in	Certification:								
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physicia Certifying Physicia Certifying Physicia Certifying Physicia Medical Examiner:	On the basis of example of example of the basis of the	knowledge, deat mination and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occu	e, and due to the corred at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	ithin (Med	29b. Signature and title of dertifier	and manner stated.		29c. Licens	se number	25	9d. Date signed (M	onth, Day, Year)
	6 전 Milit		Ill run							
•	JCA,		30. Name and address of person who compl	eted cause of death	(Item 23a) (Type	Print)	7505	/	0 16	Jell
	X341		John Whattale, on	30	5 107	Shee	a Su	to 105	ruce	2011 nol, us 3185
	Sta Registr		31. Date filed (Month, Day, Year) FC 2 0 20:	32. Regintrar's S	Signature	bares				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Register END#23eperMD,1/3/12; EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Luther Crutchfield Month 1448 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 220-24-0375 1 🛣M 2 🗆 F 80 04/19/1931 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director or 28a-f sh notified Poolesville 1 X Yes 2 No Min Montgomery 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a or Funeral 20837 USA 18511 Jerusalem Church Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2X No Black, White, etc. by 1 Never Married 2 X Married 215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Divorced 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Prince George's than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene, Firefighter County 2 12th is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marjorie Taylor James A. Crutchfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 18511 Jerusalem Church Road, Poolesville, MD 20837 Delorse Crutchfield/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Jerusalem Bapt. Ch Cm 12/31/2011 Poolesville, MD 4 Donation 5 Other (Specify) 21. Signature f Funeral Service Licer 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, ici n Abdominal Abcess aweeks disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner aweeks Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Exami months Cause (Disease or injury The law requires that the death certificate be executed use as the burial transi C metastasie and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Dav Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မ 1 Npatient 2 SR/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at After work?
1 Yes 2 No 1. Natural 5 \square Pending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number December 25. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Dr Rockville MI 9901 31. Date filed (Month, Day, Year) State 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 12/22/2011 Physician/ 3:05 aM ALLISON HUGHES CLAGGETT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Director <u> 220-07-1529</u> MD 6/4/1916 95 ms 23a or 28a-f show must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No Anne Arundel Annapolis MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 Funeral 3406 Chesapeake Walk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces?

XYes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 □ Divorced Black Completed Year or Dates 1942-1946 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) <u>Governm</u>ent - MCPS Community Coordinator/MCPS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ethel Billows Charles H. Clagett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3406 Chesapeake Walk, Annapolis, MD 21403 Laverne Davis / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Norpeck Memorial Park 12/29/2011 Sandy Spring, MD 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Accident Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause E. t. J. J. J. J. S. Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last for use as the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death signed by the a Id be detached f 1 L Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Hypertension should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus s certificate has bilirector, page 2 s autopsy performed? 1 Yes 2 No Chronic Kidney Disease 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 M Other (Specify) Hospice 1 ☐ Yes 2 🔀 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending injury within 24 hours after death.

To the Funeral Director; A completely filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R143201

Registrar
DHMH 17 Rev 06-201

State

Suite 100, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Piccard Drive.

Registrar's Signat

Miller.1355

28 2011

ebrah

31. Date filed (Month, Day, Year,

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Francis Cahill Day a_M 26 Dec Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Rehab. & Nursing Ctr. Sandy Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 26, 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 054-12-5650 93 Months Hours Min Director 1918 New York Usual Residence of Decedent show ntal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville Maryland Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4701 Rams Head Court 20853 **USA** 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 If Yes, Give Vear or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. WWII SpecifWhite 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Public Safety-Elementary/Seconday (0-12) College (1-4 or 5+) <u>Professional Firefighter</u> NY City Fire Dept is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ည John F. Cahill Mary Ann Shannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Clare M. McHugh/Niece</u> Rams Head Ct., Rockville. MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. 31 cemetery, crematory or other place) 1 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 Hawthorne, New York 22. Name and Address of Facility Cole Funeral Services, P.A. 21. Signal of Funeral Service License 4110 Aspen Hill Road, #100, Rockville, 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Preumonia 29 Hours Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last -burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No g Unknown the signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 X No 3 Probably 4 Unknown s been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? this certificate ☐ Yes 2 ☐ No 2 (4) N 25. Was case referred to medica director, Be 26. Place of Death (Check only one) examiner? မ 2x No 1 🗌 Inpatient 2 🗎 ER/Outpatient 3 🗌 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury work? 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D33700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. WASITSA MUS Howe WILLIAMSPORT

Registrar

State

31. Date filed (Month, Day, Year)
DEC 28 2011

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 8:17 Anita J. Diehl Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 8. Date of Birth (Month, Day, Year)
12/5/194 . Age (In vrs. last birthday Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 🗆 M 2 🖵 F Director 291-46-6435 Ohio within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 🛶 Yes 2 🗌 No MD Carrol1 Union Bridge 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r Funeral 19 South Farquhar St. 21791 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Completed er than "natur", the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event, the M one. College (1-4 or 5+) Teacher /Sub Teacher Homemaker/ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward N. Warner Svlvia Marino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stan T. Diehl Husband South Farquhar St. Union Bridge MD21791 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Piney Creek Cemetery12/29/1 Taneytown MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 17340 Little's F.H. 34 Maple Ave LittlestownPA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dreumon disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** example of the service of the servic Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by filled in by the funeral director, page 2 should be Division of Vital Records. 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 🗌 Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ER/Outpatient 3 DOA Inpatient 2 🗆 28a. Date of injury (Month, Day, Year) 27. Manaer of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred hours after death. Ineral Director: After Natural 5 Pending 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and adjust the fersion was find 200 Memorial est person you completed cause of death (Item 23a) (Type, Print) esT 31. Date filed (Month, Day, Year) Registrar's Signatur State 27

DHMH 17 Rev 7/2000

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 43097 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Mae Duncar 26/11 11:10pm Janie Medical 4a. Facility Name (if not institution, give street and number)
Brighter Day Assisted Living 4b. City, Town, or Location of Death Silver Spring 4c. County of Death
Montgomery **Examiner** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex **Funeral** Social Security Number 85 Days Month, Day, Yea 9/16/21 Country) **KY** Director 1 □ M 2**XX**F 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director Silver Spring MD Montgomery ms 23a or 28a-f s must be notified 1 Yes 2XXNo 10e. Street and Number 10302 Nolcrest Drive 10f. Zip Code 10g. Citizen of What Country? 20903 Funeral USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Black Examiner Armed Forces?

1 Yes 2 XX ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XX Specify. If Yes, Give Year or Dates Specify er than "natural", the Medical Exa Completed 3XXWidowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry المالية المال Elementary/Secondary (0-12) permit. Page 1 and 2 should be filed withi. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic personnes. Domestic Domestic Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mollie Parrish James Henry Tandy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10302 Nolcrest Dr., Silver Spring MD 20903 19a. Informant's Name/Relationship (Type, Print) Woodlee /Daughter Yolanda Date 12/30/201 opation - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 XXurial 2 Cremation 3 Removal from State Green Meadows Memorial Cemetery Louisville, KY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee VICTOR Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 Jia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ ardiopulmenary disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ascu the burial-transit Cause (Disease or injury that initiated events 1a and Due to (or as a consequence of) resulting in death) Last attending physician Cerebrai Vorcular accidents Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 Month Pregnant at time of death 5 Other (specify) No tate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requires 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy Hyperlipidemea 1 Tes 2 🗌 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Medical Certificate: To Be ASSISTE LIVIA examiner? Other: 4 Nursing Home 5 Residence 2 PRIO Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 27 2011 D0031654

DHMH 17 Rev 06-2011

State Registrar 2033 Penderbrooke Dr.

Crownsville,MD 21032

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signature

Serlemitsos

John P. Sen
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, La	ast)			inouto or	D Gutti		2. Date of De			3. Time of Death
	Physicia Medic		Lillian M.	Downs						Decemb	er Day 21	2011	2:30 P M
	Examin		4a. Facility Name (if not institution, giv	e street and numb	per)		4b. City, Town, o		of Death		4c. County		
-			Wicomico Nursi	ng Home			Salish		21.5		Wico		
	Funeral Director			Sex 1	7. Age (<i>In yr</i> s. <i>Ia</i> : 83	st birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birl (Month, Da Feb.	y, Year 1928	9. Birthp Count Mary	place (State or Foreign Tand
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Sas or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Licer		Sal		Cremato		12/2		Salisbu neral H		ld.
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ב ב	Attending er death. ector: After by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	pe 28e. Place o	of Injury - At hon g, etc. (Specify)	ne, farm, stre	et, factory, office		2		Street and Numb	er or Rural	Route Number,
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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The Heaver Name of Parts The Heaver Name of	the N	ᄚ	4 York Street, Apt. 12 21787		USA
Signature of Funcient Service Library and Address of Facility Myers—Durboraw Funeral Home 13.6 E. Baltimore St. Taneytown, MD 21787 23.9 Fall Library to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart library. Using not cause on each line. Italian to the control of th	with	ā	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	TAC			re, MD 21223	2
Registrar DEC 9 7 2014 American					

DHMH 17 Rev 1/2001 OCME 2006

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: this After Director:

with the Maryland

Baltimore, Maryland 21215-0036

Certification:

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year) 12-13-2011

28b. Time of 4:30

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Home

28c. Injury at Work? 1 ☐ Yes 2 📉 No

Fall from standing

28f. Location (Street and Number or Rural Route Number, City or Town, State) 51 N. Court St., Westminster,

29a. Certifier (Check only one)

Medical

1 Natural

Accident

3 🗌 Suicide

4 Homicide

t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of

 $H \cap$

29c. License number

29d. Date signed (Month, Day, Year)

ompleted ause of death (Item 23a) (Type, Print) 30. Name and address of

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State Registrar

31. Date filed (Month, Day, Year)

HD 32. Régistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10e & 26 per DVR G923 1/19/12 dk
State of Maryland / Department of Health and Mental Hygiene 43101 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:30 PM Victoria Fuller 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Bowie 11000 Lake Arbor Way If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Hours Min (Month, Day, Year) Director 169-22-3635 1 M 2 N F 92 12/24/1919 PA Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Rowie Prince George's 1 1000 Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA -1100 Lake Arbor Way 20721 items ; death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, the Medical Examiner Black, White, etc. Armed Forces or by 1 Never Married 2 Married 72 hours after 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes If Yes, Give 1 Yes 2 No Specify: Specify: Black 'natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Domestic 10 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Janon Maginley Reginald Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item Phyllis Williams / Daughter 11000 Lake Arbor Way Bowie, Md 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Ft. Lincoln Crematory 1/3/12 Brentwood, Md Signature of Funer Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd Brentwood, Md 20722 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Promician/ disease or condition resulting in death) CHF Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be phys the b Box 68760 attending phy IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 🕱 No ed by the a detached f 1 ☐ Yes ∠ ∠ g ☐ Unknown g | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed HTN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Alzheimer's Disease autopsv has le 2 page 2 🗌 No Yes 2X No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) e B daughter's

4 □ Nursing Home 5 점 Residence & Other (Specify) residence examiner? Hospital Other: 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending М Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 - Homicide determined Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 20065418 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20740 College Park, Md 6201 Greenbelt Rd. #M-17 Vitalis Ojigbe, M.D. 31. Date filed (Month, Day, Year) JAN 0 3 2013 32. Registra Signat Registrar

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Vital

Division of

DHMH 17 Rev 06-2011

100 E. Carroll St. Salisbury m)

P.R.M.C.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fields Rosalie Medical County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** isbury omic If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral Director** 214-36-5432 1 🗆 M 2 🗓 F Yrs 2-6-1938 Maryland 73 28a-f show 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Eden Wicomico 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21822 26442 Walnut Tree Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No 9 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Wicomico County Secretary Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ White Marie Fields John Albert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalie 27140 Walnut Tree Road, Salisbury, Maryland 21801 Donald R. Fields - Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Siloam, Maryland 4 Donation 5 Other (Specify) 12-27-2011 Siloam Cemetery permit. Bounds Funeral Home 22. Name and Address of Facility E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Phyllician/ caroli disease or condition Medical resulting in death) Due to (or as a con leg Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): nding physician ause as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mg for Pregnant at time of death 5 Other (specify) the a g 🗌 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 Yes 2 No 3 Probably Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available 24a. Was an autopsy performed? 1 Yes 2 No has prior to completion of cause of page 2 death? this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) lahe 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No at El Certificate: 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After mpletely filled in by the funer Natural Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [only one and title of certifier 29b. Signatur 29c. License number 29d. Date signed (Month. Day, Year) D63199 12/21/11 duress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a SAUSBURY, EASTERN SHORE OHR Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per npg 23,019137 F2 and Health and Mental Hygiene 43104 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marie F. Fitzgerald 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WM Regional Medical Center Cumberland If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Unde 8. Date of Birth **Funeral** (Month, Day, Year) Months Min Director 220-10-7359 1 □ M 2**X** F 91 12/20/1920 WV show 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Completed by Funeral Director 28a-f X☐ Yes 2☐ No WV Mineral Keyser 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 26726 USA 116 Center Street item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black White etc Yes 2 No Yes, Give 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🙀 No Specify. 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ H. P. Inskeep Myrtle Connell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 92 First Street, Keyser, WV 26726 Maureen Marsh/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/31/2011 Queen Point Cem. Keyser, WV Signature of Funeral Service Licensee 22. Name and Address of Facility Markwood Funeral Home, Inc. Box 912, P.O. Kevser, WV 26726 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Meumonia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of Due to (or as a consequence of): use as the burial-tran and that initiated events resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2. No 3 Probably 4 Unknown 1 Yes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

31. Date filed (Month, Day, Year) State

30. Name and address of poson who completed cause of death (Item 23a) (Type, Print)
Tammy Keating, CRVP, 12500 Willowbrook Rd., Cumberland, MD 21502 32 Registrar's Signature

eating

Registrar

RN 194124

12011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17:29 M 2011 Greene, Jr. Shedrick Thomas Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges <u>Clinton</u> <u>Southern Maryland Hospital</u> Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Director 227-58-1919 1 🖾 M 2 🗆 F 65 03/02/1946 Virginia show 10d. Inside City Limits f Health and Mental Hygiene. item 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1X Yes 2 No Forestville Prince Georges MD 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 20747 2123 Roslyn Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 No If Yes, Give 1964— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Divorced 4 Divorced **Black** Year or Dates. 1970 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Department of the Navy Security Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred Miller Shedrick T. Greene, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2123 Roslyn Avenue Forestville, MD Elva Greene - Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Lincoln Cemetery 1/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Ft. Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Che attam Sour Mentgemeny 3401 Bladensburg Road Brentwood, MD 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. MyoCy-dil Immediate Cause (Final Physician/ 453.W disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Ur b . d Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant
9 Unknown Pregnant at time of death been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autonsv performed? death? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending s after death. Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 27/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar
DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 23 Physician/ 0500 M Kevin L. Glover Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suitland Prince Georges 6702 Poplar Road Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Hours 1 X M 2 X F 1957 Wash Director 578-78-8171 Usual Residence of Decedent should be filed within 72 hours after death with the Maryiand and Mental Hygiene.
'Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 Yes 2 No MD PG Suitland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20746 United States 6702 Poplar Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PG Public Schools 4 Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Pearlene Swann Julius Glover 1 and 2 should be if Health and Mer item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Salmon adelphi Tiffany Glover/daughter or other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery Clinton, MD& Edwards F.H. 22. Name and Address of Facility Hodges 21. Signatu of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, MD. 20746 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each Immediate Cause (Final disease or condition Atherosu Pnysician Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Due to for as a ponsequence of Examine Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year for Pregnant at time of death signed by the a d be detached f P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records, cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed ☐ Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) in by the funeral director, Be examiner? Hospita 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 욘 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner - Ceath 28d. Describe how injury occurred 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No Matural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Deurial 2 4 X Donation	☐ Cre <i>m</i> ation		moval from	State	20b. Pla cer	ce of Dispo metery, crem	sition (Nan	ne of ther place	e)		Date	20c.	Location -	City or ⁻	Town, State
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.	Sicially	23b. Was decedent in the past 12 / 1 Yes 2 S 9 Unknown	months?	23c	1	Birth 2 nant at ti	Fetal	death 3	Ectopic Other (sp		<i>y</i>				23d. Date Mor		very Day Year
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To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Medical	29a. Certifier 1	Certifying	Physicia	n: To the b	est of my	y knowled	dge, death o	ccurred at	the time	, date and	place, a	nd due to the c	ause(s)	and manne	er as sta	ated.
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		Name and addre	ess of person	who con	NY	e of deat	th (Item 2	3a) (Type, P	rint) FEO	ISE	the	HWA	ty ANO	VAP	015	M	122012
State Registrar		31. Date filed <i>(Mont)</i>	AN 18	2012	32/R	egistrar's	Signatu		Kel								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 608 Betty Louise Garrett Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO SALISBUM Medical KROLONAL If Under 1 Year If Under 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year, 214-28-8145 Usual Residence of Decedent **Director** 1 □ M 2X F 10-4-1931 80 MD 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits death with the Maryland Director r 28a-f sl notified 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ritems 23a or ner must be r Funeral 21801 USA 110 W. Isabella Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian er than "natural", or iter the Medical Examiner Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 X No Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify:Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Production Worker Hatchery Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Boston Bertha R. Hayman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> 28757 Ocean Gateway, Salisbury, MD 21801</u> <u> Victoria Kelly/Daughter</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place). C 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Direct Cremation, 1-2-2012 Dover, DE Ignature of A neral Service Licenses 22. Name and Address of Facility 917 W. Isabella St. Funeral Home Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final diomy Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE 23c. If yes, outcome of pregnancy
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 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page 2 certificate the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 1 No မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year who completed cause of death (Item 23a) (Type, Print) 2TC 30. Name and address of pe Salisbum M lan 31. Date filed (Month Year) egistrar's Signature State 3

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43109 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Month OE C Physician/ 19:10 AM GRAY SANDRA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Director 578-64-4957 1 🗆 M 2 🗓 F 64 MARCH 7, 1947 WASHINGTON, DC Usual Residence of Decedent r 28a-f show notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1X Yes 2 No CALVERT MD LUSBY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or iner must be r Funeral USA 334 CEDAR LANE 20657 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Fant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner munical or other traumatic event. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

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5 Other (specify) in the past 12 months?

1 Yes 2 X No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò STAGE RENAL DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2: autopsy performed death?
1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 5 Pending injury Natural work? 1 Yes 2 No Investigation Accident filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) uple MD 00053150 2012

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State Registrar

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32. Regist ar's Signature

Sanhajo Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

alcumale

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 7:37 Arthur Jay Gray Jr. December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Wicomico Salisbury 105 Overlook Drive, Apt. 1-C Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) Funeral Min. Hours 231-42-8050 Director 1 🗶 M 2 🗆 F 77 Yrs 09/20/1934 Virginia Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 28a-f 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 21804 USA 105 Overlook Dr., Apt. 1-C permit. Page 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Highene. Important: If item 27 is marked other than "natural", or items 2 any injury or other traumatic event, the Maria 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 X Yes 2 No Black, White, etc þ 1 Never Married 2 X Married 1 Yes 2 X No Specify: Specify: White Year or Dates. Army 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Grain Dealer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Bess Rowley Arthur Jay Gray Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores P. Gray/spouse 105 Overlook Dr., Apt. 1-C, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Anatomy Gifts
Registry ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/20/2011 4 N Donation 5 ☐ Other (Specify) Hanover, MD Stag ature of Funer | Service Licensee 2HOTIOWAY FUNETAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ SUN Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) been signed by the a should be detached Unknown Hospital or Attending Physician: The law requires that the t24 hours after death.
Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an completely filled in by the funeral director, page 2 performed' death? 1 Yes No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 15 Residence 6 Other (Specify) 10 Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Within 2 To the F only one 29b. Signatule and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 63199 20/11 address of person who completed cause of death (Item 23a) (Type, Print) Name 910

State Registrar 04

31. Date filed (Month, Day, Year) UEC 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d per med cert G924 2/6/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert J. Gillette 2011 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death . 4b. City, Town, or Location of Death **Examiner** KICOMICO POIDHAL 5A 6136414 6 Sex If Unde 8. Date of Birth 9. Birthplace (State or Foreign last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) 214-32-6752 1 🔏 M 2 🗆 F **Director** Yrs 11-7-1929 82 VA 10d. Inside City Limits at 10a. State 10c. City. Town or Location Director notified 28a-f 1 Yes 2X No Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be Funeral items 23a USA 21804 701 Priscilla Street permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items one. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deced Armed Forces? Ves 2X No 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. þ 1 Never Married 2 XMarried Specify Black 1 Yes X No Specify. If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Wheatley Trucking Co Truck Driver 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Gillette Lee Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Street, Salisbury, MD 21804 <u>Elizabeth Gillette/Wife</u> 701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Garden 2-23-2011 Hebron, MD Boring 22. Name and Address of Facility 17 W. Isabella St. of Funeral Service Licens 21. Sign MD 21801 Funeral Home Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL Ph. i ian disease or condition Medical resulting in death) Examiner ILAY DISPASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last pue burial-trai Physician/Medical that the death certificate be Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Month 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 page 2 this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No Certificate: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred injury 1 Natural 5 Pending __ Accident Investigation within 24 hours after deal To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) aus February 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAL136411 , MU 3510 0

State

Registrar

31. Date filed (Month, Day, Year)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20,2011 Physician/ December 1 12:45 am Lillian Gechter Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville 9. Birthplace (State or Foreign Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 🗆 M 2 🎗 F 044-18-5078 89 Connecticut Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d, Inside City Limits 10b County 10a, State 10c. City. Town or Location Director 1 Yes 21 No Rockville Maryland Montgomery 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 20852 U.S.A 6121 Montrose Road death 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 3 1 Never Married 2 Married within 72 hours after Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White "natural", Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (Unobtainable) Ida (Unobtainable) Tower 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 sh it of Health a : If item 27 is P.O. Box 414, McLean, Virginia 22101 Andrea Sloan - Personal Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of Important: If it any injury or o 1 🗓 Burial 2 🗆 Cremation 3 🗓 Removal from State 12/29/2011 Young Israel Cem. Easthaven, CT 4 ☐ Donation 5 ☐ Other (Specify) 21. Si atur of Fineral Ser 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MO0709 11800 New Hampshire Ave. Silver Spring. MD 20904 23a. Parl 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ sementa disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): and Due to (or as a consequence of) resulting in death) Last buria attending physician Physician/Medical certificate be Box 68760 as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown jo 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The law has death? 1 ☐ Yes 2 ☐ No certificate within 24 bours after death.

To the Funeral Director: After this certification of the funeral director, and the funeral director, is 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending (Month, Day, Year) injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 [29d. Date signed (Month, Day, Year) 29b. Signature and title D69568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rodwille 6121 montree Rd MD A. Chilakamarn

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31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

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rtific	2	23b. Was decedent pregnant in the past 12 months?	e 1 Live		2 Fe	etal death	3	Ectopic pr	egnand	у	Month		ay Year
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Maryland 21215-0036	is filed within 72 hours after death with the Manyland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	1 X Never Marrie		Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	Ç No			ecify Cuba	Specify:	Puerto I	Rican, etc.)			, White,	
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ryla	2 should be file th and Mental I 27 is marked o traumatic eve	_	JOHN L. 19a. Informant's Nar		no Drintl		1				_	TH HAGA				
Ma				GAN - MO								l Route Numb CHESTER				AND 21620
ore,	ge 1 and 2 it of Healt : If item 2 or other 1		20a. Method of Dispe	osition	Removal from State	20b. P	lace of Disp emetery, cre	osition (Na	ame of			Date		Location -		
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Bal	permit. Pa Departmer Important any injury once.		21. Signature of Min	eral Solvice Licens	- 11 14			2. Name a	and Addres	s of Facility	BEI	N & NEV	MAM	FUNE	RAL	HOME, P.A. 21620
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~ F	hysician/	1	Immediate Cause (F disease or condition	inal	-	lmon	a									Onset and Death
أمسا	Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):									
		iner	Sequentially list con it any, leading to infli- cause. Enter Under	ditions,	b. Sue to (or as:	3 DUNBEQU	ianta of;:									
	executed an and rrial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) Li	njury	c. Due to (or as											
			resulting in death) C	asi	d.	a consequ	ence on.									
876	tificate ng phy as the	Medi	IF FEMALE:		u											
Box 68760	The law requires that the death certificate be ate has been signed by the attending physici page 2 should be detached for use as the by	Physician/Medical	23b. Was decedent print the past 12 mm 1 Yes 2 Unknown	nonths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic Other (s	pregnancy	У				23d. Date Mon		very Day Year
P.O.	that th ned by e detac	by Ph	Part II. Other signific	cant conditions co	ntributing to death b	ut not resi	ulting in the	underlying	cause giv	en in Part I.		23e. Did t	tobacco	use contri	bute to t	the cause of death?
ds,	/ requires been sig should b											1 🗆	Yes 2	2 🗆 No :	3 🗌 Pro	bably 4 Unknown
Division of Vital Records,	has be	Completed										24a. Was auto		, pi	ere autorior to co eath?	ppsy findings available empletion of cause of
E E	an: The tificate tor, pa	Be Co	25. Was case referred	d to medical					26. Pla	ice of Death	(Check	1 Tes				2 🗆 No
Vit.	nysicia nis cer I direc	To B	examiner?	No	Hospital:	ent 2 🗆	ER/Outpatie	nt 3 🗆 [Otha	r:		me 5 \square Resi	dence	6 🗆 Other	(Specify	y)
οι	ling Pl	ate:	27. Manner of Death 1 Natural	5 Pending	28a. Date of inju (Month, Day	ry , Year)	28b. Time o injury		28c. Injury work	? _		8d. Describe	how inju	iry occurred	d	
Sion	Attenc r death cctor: o	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Place of Inju			M reet, facto		Yes 2 □ N	-	28f. Location (Street a	nd Number	or Rura	d Route Number,
ρί	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2				building, etc							City or To	vn, State	e)		
;	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check 2 l	Medical Exami	ician: To the best of ner: On the basis of e	xamination	and/or inves	stigation, ir	n my opinio	n, death occi	urred at	the time, date :	and plac	e, and due	to the ca	ause(s) and manner stated.
1	To the within To the Compl		only one) 3 l 29b. Signature and ti		e Practitioner: To the	e best of m	ny клоwieage		curred at tr c. License				29d. Da	ate signed	(Month,	Day, Year)
	2			1					RES	3-00	00		De	cembe	21	26 2011
	m ₅		30. Name and address		ompleted cause of d	ath (Item	23a) (Type)	Print) P	SA.	Ba	14	mere	21	MD.	21	1287
	Stat Registra				32. Regiona	ar's Signati	ure	has		1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 43115 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Harvey E. Harding 2011 5:40 A. Dec Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Svkesville Carroll Transitions Health Care 7. Age (In yrs. last birthdav) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year) Pec. 30, 1952 215-48-9369 Director 1 🔀 M 2 🗆 F 58 Maryland Dec. 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location must be notified at Director Carroll 1 Yes 2 XNo Maryland Sykesville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō Funeral 23a 7309 2nd 21784 United States Ave death \ 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. or i þ 1 X Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural" Completed 3 Divorced 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Drywall Hanger Co. emplovee Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental I fitem 27 is marked o h and Mental I ပ Franklin Harding Dorothy Horton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Lohoefer sister 2605 Gillis Falls Road PO Box 104 Woodbine, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Union Chapel Cemetery Dec. 27, 2011 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home & Cremato
1212 W. Old Liberty Road Sykesville,
r heart failure. List only one cause on each line. 21. Signature of Funda J Service Lights once. & Crematory, Approximate Interval Between Onset and Death heart failure. List only one caus Immediate Cause (Final disease or condition ead Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 124 hours after death.

Funeral Director; After this certificate has L autopsy perform death? 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural injury Accident 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ろつつ nth, Day, Year) egistrar's Signature DEC 2 neces Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December. 1019 Mildred W. Hale 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Wicomico 8. Date of Birth (Month, Day, Year) Social Security Number If Unde Birthplace (State or Foreign Country) **Funeral** 205-10-2293 **Director** 1 M 2 XF 06|01|1919 92 Pennsylvania Usual Residence of Deced 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** must be notified 1 Yes 2 X No Marvland Worcester Ocean Pines ю Of. Zip Code 10q. Citizen of What Country? 23a 15 N. Pintail Drive 21811 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 'natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced White Year or Dates d other than "natura 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Registered Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ C. Spurgeon Warner Flora A. Bender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Charles Warner 15 N. Pintail Dr., Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State Department of F Important: If ite any injury or ot once. Date 1 Burial 2 Cremation 3 X Removal from State Mount Rose Cemetery 01 07 2012 York, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 24 Hows Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Day Pregnant at time of death Month Year 2 100 1 Yes 2 U signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Disease 2 No 3 Probably 4 Unknown 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has laws. autopsy performed? 1 Yes 2 THO completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 1 No Other: ည 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 5 Pendina (Month, Day, Year) Accident
Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the 1 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl of certifier 29d. Date signed (Month, Day, Year) 2011

Sta

Registrar

30. Name and address of pe

Teff Etherton

1. Date filed (Month, Day, Year)

and

SALIBBIARL

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 27 AM Dolores Anita Hitchens Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice at th omico 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min 09 29 1948 Maryland **Director** 220-52-9023 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 🗌 Yes 2 🕱 No Mardela Springs Maryland | Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21837 10085 Sharptown Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc þ 1 Never Married 2 Married 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetology Hairstylist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anita Myrtle Hudson Ralph Meyers Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10085 Sharptown Rd., Mardela Springs, MD 21837 John Homens husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Anatomy Gifts
Registry 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 12 30 2011 Hanover, Maryland 22. Name and Address of Facility
Holloway Funeral Home P.A. Signature of Funeral Service Licenses Salisbury, Maryland 21804 Snow Hill Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Tectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 9 Unknown Day Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 this certificate 2 1 N Yes 2 1 1 Yes 25. Was case referred to edical funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending 1 A atural 2 🗌 No Accident Investigation 1 Yes the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29h 29c. License number 29d. Date signed (Month, Day, Year, who completed cause of death (Item 23a) (Type, Print) 176

State Registrar 37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 12 8:00 AM Frederick Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 2528 E Preston Street Baltimore 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 56 Yrs. 1 **X**M 2 □ F unk 07/13/1955 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 ▼ Yes 2 No 10e. Street and Number ò 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 2528 E Preston Street 21213 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry عد filed wn. خا Hygiene. خد than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th 2yrs Supervisor Food Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 John Hite Louise Gentry other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or any Sheryl Hite 2528 E Preston St Baltimore MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Atlantic Crem 1 Burial 2 X Cremation 3 Removal from State 1/6/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover_MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician, nteckin disease or condition resulting in death) Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and-tranthat initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year be detached g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End- Stafe Crowney failuse 1 Yes 2 No 3 Probably 4 Unknown Cachexia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Receivent Wrosepsis performed? Yes 2 No death? 1 Yes 2 No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 Yes 2 No Investigation 3 Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1-10-20/2 19829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway Baltomore MD 2/2/2 20/ E. Claruersiay Shen. M.D STEUR

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, JAN 1

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	4	For State	State of M	arylan		artment of H		Mental Hyo	giene				
		Registrar 1. Decedent's Name (First, Middle, Las	t)		Cer	tificate of E	Death	2. Date of Dea	Reg. No	20	++	3. Time of D	119
Physician. Medica		William Joseph	•					Decemb		23, 20	911	6:00A	
Examine		4a. Facility Name <i>(if not institution, give</i> Renaissance Gardens a		Villag	<i>j</i> e		Location of Death Spring		4c. Pr	County of	Death Geo	rge's	
Funeral Director		100 20 0000	ex M 2 □ F	e (In yrs. Ia	nst birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Aug • 16		24	9. Birthp Count MISS	olace (State or a try) Ouri	Foreign
or 28a-f show	. It	Usual Residence of Decedent 10a. State Maryland Prince G	eorge's		, Town or Loc						1	0d. Inside City	
ith the Ma	rai Dire	10e. Street and Number 13203 Taney Drive				10f. Zip Code 2070	5		-	izen of Wh		itry?	
amin 3	2	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent B Armed Forces? 1 🛆 Yes 2 🗌 If Yes, Give		l1	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto			14. Race - Black,	Americ White,	an Indian,	
natural dical Ex	Completed	3 X Widowed 4 ☐ Divorced 15. Decedent's E. (Specify only highest green)	Year or Dates.	WII	16a. Deced	ent's Usual Occupa	ation	kina	16b. Ki	Specify: ind of Busi			
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J be filed w Aental Hyg rked othe rtic event,	9	17. Father's Name (First, Middle, Last) William J. Hickey					18. Mother's Nan						
d 2 should alth and N 27 is ma		19a. Informant's Name/Relationship (7) Thomas Hickey -so				g Address (Street a Taney Di							
Page 1 an Jent of He Int: If item Iny or othe		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specif		CE	emetery, cren	sition (Name of natory or other plac ven Cenete r		Date 3/2011		ocation - C Ter Spi		wn, State Marylan	rd
permit. Departm Importa any inju		21. Signature of Funeral Service License	·	1	D86	nardandviderer 00 Powder	Borgward	Funera	1 Hc	me,]	PA		
hysician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line	ð.	n. Do not ente		g, such as cardiac	or respiratory arr	est,			Approximate Interval Betwo Onset and De	reen
Medical Examiner		disease or condition resulting in death)	Due to (or as:	a consequ	ence of):	CELEDIA.	r vascura	ar Disea	<u> </u>		\top		
and and all-trapsit	3111112	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as										
uria C	₽ I	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):								
It his beautiful care be executed to the attending physician and stached for use as the burial-transit burial-transit.	Sicial / Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3	Ectopic pregnanc	у			23d. Date Month		ery Day Ye	ear
		Part II. Other significant conditions of Advanced Dementia	ontributing to death b	ut not resu	ulting in the u	nderlying cause giv	ven in Part I.					ne cause of dea	
rate has been signed page 2 should be d	mblere							24a. Was a	an esv	24b. We	ere autop	osy findings av	/ailable
ificate or, pag		25. Was case referred to medical				26 Pla	ace of Death (Che		rmed? 2 No	1 [Yes	2 X No	
his certification of the control of		examiner? 1 ☐ Yes 2 🂢 No	Hospital: 1 🗌 Inpati	ent 2 🗆	ER/Outpatien	Othe	ar:	ome 5 Resid	lence 6	Other (Specify,)	
of Attending of after death. Director: After the in by the funeral of attending of a state of a st		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b.		ry /, Yea <i>r</i>)	28b. Time of injury	28c, Injury work M 1 🗆	/ at ? Yes 2 □ No	28d. Describe h	ow injury	occurred			
ins after do an all Director led in by the control of the control		3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ıry - At hoı c. <i>(Sp</i> ec <i>ify)</i>	me, farm, stre	et, factory, office		28f. Location (S City or Tow.	treet and n, State)	d Number o	or Rural	Route Numbe	er,
the Funeral		(Check 2 Medical Exami only one) 3 Certifying Nurs	sician: To the best of ner: On the basis of e se Practioner: To the	xamination	and/or invest	igation, in my opinio	on, death occurred a	at the time, date a	nd place,	and due to	the cau	use(s) and mann	ner stated.
641		29b. Signature, and title of certifier	22mm	ea	DCRI	29c. License	number 5366	e7	29d. Dat	e signed (f	Month, I	Day, Year)	
		30. Name and address of person who c Eileen Gemmell, C	empleted cause of d PNP 3160 (eath (Item Grace	^{23a)} (Type, P field	Road Silv	ver Sprin	ng, Mary	land	1 2090	04		
State Registrar		31. Date filed (Month, Day, Year) OEC 28 201	32. Registra	ar's Signat	ure for	رادی							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year 0915 Elinore Shrager Heyman DEC 22, 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Brighton Gardens N. Bethesda If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year JUL 29, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 □ M 2 X F NJ89 156-01-3746 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No MD Montgomery N. Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 5550 Tuckerman Lane 20852 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Caucasian Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank of America Receptionist Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shrager Bess Silverstone Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7517 Springlake Drive, C-1, Bethesda, MD 20817 Gail Karp / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12/23/2011 Glen Burnie, MD 22. Name and Address of Facility
Thibadeau Mortuary Service, p.a. 21. Signature of Funeral Service Licensee 1/m M00956 7 Park Avenue, Gaithersburg, MD 20877 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT disease or condition resulting in death) Due to (or as a consequence of) HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tua to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ØNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ARTHRITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗀 No 1 Tyes 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident

Physician /Medical Examiner

permit. Page Department of Important: If any injury or once.

Physician

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Examiner

Director

Completed by Funeral

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Examiner

Physician/Medical

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Certification: To

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?? is marked other than "natural", or items 23a or 28a-f show traumatic evant, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If itam 27 is marked other than "natural", or Ite

Baltimore, Maryland 21215-0036

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law requires that the death certificate be executed To the Hospital or Attanding Physician: within 24 hours after death.

To tha Funaral Diractor: After this certifica completely filled in by the funeral director, t

Division of Vital Records, P.O. Box 68760

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6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D53691

29d. Date signed (Month, Day, Year)

December 22, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3200 TOWER OAKS BL., #110, ROCKVILLE, MD 20852 AJAY REDDY M.D.,

31. Date filed (Month, Day, Year) State **DEC 28 2011** Registrar

3 🗌 Suicide

29a. Certifier

4 Homicide



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jenkins Frank R. 8:18 p 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG Oxon Hill 510 Barrymore Dr. 5. Social Security Number 8. Date of Birth 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1-09-1956 1 🏻 M 2 🗆 F Months 578-80-9684 55 Wash. **Director** Usual Residence of Decedent 28a-f show 10b. County death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits notified at Director Oxon Hill MD PG ¥ Yes 2 □ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 20745 USA "natural", or items 23a 510 Barrymore Dr. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after Black 1 ☐ Yes 2X No Specify: Specify: Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Fork Lift Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental His marked of Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce. ၉ Juanita Nelson William Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Barrymore Dr. Oxon Hill, MD 20745 Catherine Jenkins/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Heritage Memorial Pk 1-2-2012 Waldorf, MD 2 | Signatur of Funeral Service Licens 22. Name and Address of Facility Ronald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 COWOL 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of; To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Nonknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed death? 1 ☐ Yes 2 ☑ No certificate 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State

JAN 0 3 2012 Registrar

31. Date filed (Month, Day, Year)

Sedicon ICWU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0055314

29d. Date signed (Month, Day, Year)

2011

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/

Medical

Director

Completed by Funeral

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Examiner

Funeral

Director

show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Physician/

Medical Examiner

Baltimore, Maryland 21215-0036

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dical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No g ☐ Unknown	23c. If yes, outcome of pregnancy 1	pic pregnancy er (specify)		23d. Date of del Month	livery Day Year
ted by Pt	Part II. Other significant conditions	contributing to death but not resulting in the underly	ing cause given in Part I.			the cause of death?
Complet				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of s 2 No
Be	25. Was case referred to medical examiner?	Managhali	26. Place of Death (Check	(only one)		
ပ	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	□ DOA Other: 4 □ Nursing Ho	me 5 Residence	6 🗆 Other (Spec	ify)
ficate:	27. Manner of Death 1	28a. Date of injury (Month, Day, Year) 28b. Time of injury M	28c. Injury at work?	28d. Describe how inju	ry occurred	
al Certi	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	200 Place of Injury At home form street for	ctory, office	28f. Location (Street ar City or Town, State		ral Route Number,
Medical Certificate:	(Check 2 Medical Exam	ysician: To the best of my knowledge, death occure niner: On the basis of examination and/or investigation rse Practioner: To the best of my knowledge, death of	n, in my opinion, death occurred at	the time, date and place	e, and due to the	cause(s) and manner stated.
_	29b. Signature and title of certifier	the mo	29c. License number D0041587	29d. Da	ate signed (Month	n, Day, Year)

Speer Rd Chestertown, MD 21620

Registrar DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 12 0100 2011 7:00 Medical 4a. Facility Name (not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner 417 St. Lukes Road Fruitland Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🕅 F Months Hours Min (Month, Day, Year) Mary Land 88 Director 216-14-2164 21-1923 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No MD Wicomico Fruitland 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 417 St. Lukes Road 21826 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Examiner Black, White, etc. ō þ 1 Never Married 2 Married 2 X No ☐ Yes 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify. White Specify "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Manager Wicomico County 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 2 Richardson Edith Elliott John Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5859 Brook Street, Salisbury, Maryland 21801 Sharon L. Cheezum - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ACremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) of Delmarva 12-28-2011 Crematory Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licer 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one complete the complete shock and the complete shock a is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on elech line. Immediate Cause (Final Onset and Death Physician) disease or condition resulting in death) Medical Due to or as a const quence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director; After this certificate has autopsy performed' death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ N 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 [] 140 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident 2 Accider
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State within 24 hours a

To the Funeral D Medical 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signa 29d. Date signed (Month, Day, Year) 3

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who completed cause of death (Item 23a) (Type, Print)

Registrar's Signal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1):39 AM PATRICIA KYLE MARY 2 16 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula Regional Medicul Center 2011Sbur WICOMICO If Under If Under 2 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Country 214-28-4885 **Director** 1 □ M 2 🛚 F 83 JAN. 7, 1928 DC Usual Residence of Deceden or 28a-f show notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location Director 1 X Yes 2 No DELAWARE SUSSEX FENWICK ISLAND 10e, Street and Number 10f. Zip Code oř 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be i Funeral 19944 USA 1205 BUNTING AVE. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 XX Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **5** DEPT. OF COMMERCE FIELD REPRESENTATIVE permit, Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>traumatic</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SR. GRABILL JESSE BOND SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMY D. KYLE/DAUGHTER 60 29TH ST., #213, SAN FRANCISO, CA 94110 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State CREMATORY OF DELMARVA 12/28/11 DELMAR, DELAWARE 4 Donation 5 Other (Specify) Signati 22. Name and Address of Facility Service License HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 We 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician OROWAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai that initiated events Due to (or as a consequence of resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 chiknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' Yes 2 After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending work' 1 Yes 2 🗌 No Investigation within 24 hours after deatl To the Funeral Director. Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical ✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Nour

DEC

29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carroll St.

egistrar's Signature

100 E

2017

SA/13 bury

balks

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
/12••FMW.M-Ch

Certificate of Death

Reg. No. 20 State RegistramEND#2perMD, 1/3/12; ; EMW, MoCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Lynne R. Kolkmeyer December 11:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chevy Chase Montgomery 4892 Chevy Chase Blvd. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 397-46-0782 **Director** 1 □ M 2 🕌 F 64 July 19, 1947 Wisconsin Usual Residence of Dec 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified MD Chevy Chase Montgomery 1 Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 4892 Chevy Chase Blvd. 20815 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter dical Examiner by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Specify: White Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify 3 - Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ge 1 and 2 should be filed within 73 nt of Health and Mental Hygiene.

Etfitem 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William L. Kolkmever Maxine M. Menke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Elizabeth L. Holcomb/Daughter 4892 Chevy Chase Blvd, Chevy Chase, MD 20815 Date 27, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Dec Department of Important: If any injury or 2011 Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring 21. Signature of Funeral Service Licenses ,MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death • 5 yrs Immediate Cause (Final Ph. sician/ Metastatic Non-Small Cell Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Brain Metastasis 10 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): e attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d Date of delivery in the past 12 months?

1 Yes 2 X No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autons performed? death? within 24 hours after death.

To the Funeral Director: After this certificate | 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nursa Practition on To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Dec. 27, 2011 D35996

Registrar

State

2730 University Blvd. #400, Wheaton, Maryland 20902

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda M. Burrell, MD

2011

DEC 28

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death December 22, 2011 Physician/ 3:50A M Kaye Florence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Ginger Cove Health Center Annapolis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Age (In vrs. last birthday) 8. Date of Birth May 10, Days Hours Ye1917 1 □ M 2 👿 F 94 Connecticut 045-10-3846 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Maryland Anne Arundel 1 A Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 United States 4000 River Crescent Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Specify: 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Connecticut State Elementary/Seconday (0-12) 12 College (1-4 or 5+) Clerk Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph Jackowitz Katherine Goodrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 688 Gennessee Street Annapolis, Maryland 21401 Kenneth Kaye -son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Temple B nai Abraham 12/27/2011 1 X Burial 2 Cremation 3 Removal from State Meridan, Connecticut 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonaid Wors Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician Metastatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or initially that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last the attending physician and for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month n signed by the a ld be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Hypertension; Hypothyroidism 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy perform death? 2 No 2 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 **N**0 1 \square Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation М ☐ Accident 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Njide Udochi, M.D.

28

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

189

9055 Chevrolet Drive, #100 Ellicott City, Maryland 21042

December 22, 2011

11-09831 Kefas Koudaya

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.		
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		1- For State Registrar	e of DeathReg. No.													
Physicia		Decedent's Name	e (First, Midd	e,Last)							2.	Date of Dea Month		Voor	3	3. Time of Death
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Amenyog1	o A. K	oudaya /	Fath											, MD 20877
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Baltimore, permit. Pages 1 ar Department of Hec Important: If ite injury or other ir	1	1 X Burial 2 C			from State	A11 S	-		erv	,	01/08	8/2012	Ger	cmani	towr	ı, MD
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Hosp 24 ho Func tely fi		29a. Certifier (Check only		hysician: To the b												
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death comficiene be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	edical	one) 2 🗸	Medical Exa	miner: On the basi and manne		nation and/or i	nvestigatio	on, in my opi	nion, d	death occ	curred at the	he time, date	and place	, and due	e to the	cause(s)
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YEN L		Tiels	Stat	ter Ve	IL-	100		0	.C.M	I.E.			Decer	mber 3	1, 201	11
	ŀ	30. Name and addr	ess of person	who completed ca	use of dea	ith (Item 23a)									-	-
		Victor Weed	100	Assistant M		xaminer			e Str	reet, Ba	altim ore	, MD 212	23			
Sta	ite	31. Date filed (Mon	th, Day, Year)	010 32.	Registrar's	Signature	bark	1.								
Regist	ar	JAI	1102	012 Jun	me	p. 4	1000	11								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 28f per me,g925,03/29/2012dhb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 26, 201 2034 Mack L. Latham December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Fort Washington Fort Washington Medical Center 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days July 8, 1936 1 XM 2 F Hours Min Country) **NC** Months 75 Yrs. **Director** 242-60-7760 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD PG Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 1205 Portabello Court 20745 United States items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married ò þ Maryland 21215-0036 1 ☐ Yes 2 🔀No Specify: If Yes, Give Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates. Black event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Coach Cleaner Government and Mental Hygie is marked other Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Olivia Wilkes Joseph Latham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1205 Portabello Court
Oxon Hill, MD., 20745 Page 1 and 2 si ment of Health a tant: If item 27 is permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti Angela Brown/daughter Baltimore, 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State 12/31/11 cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) incoln Memorial Cemetery Suitland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. MD.20746 3910 Silver Hill Rd., Suitland, 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician/ Due to (c. as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 ending pr. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown P.O. I ed by t detach signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 □ Probably 4 □ Unknown 1 Yes peen accide 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 autopsy performed: certificate ! 000 1 Yes Physician: director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred choiced on 2 preces a bacon 27. Manner of Death 28b. Time of Certificate: injury 915 28c. Injury at of bacon work? 1 ☐ Yes 2-☐ No 1 Natural 5 Pending December 26, 2011 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, State)

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28f. Location (Street and Number or Rural Route N

State Registrar

Medical

29a. Certifier (Check

29b. Signature and title of certifier

JAN 0 3 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D54723

ivingston Road, Ft. Washington,

29d. Date signed (Month, Day, Year)

DEC. 28,201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHARLES WILLIAM LEWIS 2011 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Uicam If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) Months Hours 221-28-1503 Director 1 XM 2 □ F MAY 28, 1943 MARYLAND 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MARYLAND WORCESTER BERLIN 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10305 CATHELL ROAD 21811 USA "natural", or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 Yes 2 X No If Yes, Give Year or Dates UNKNOWN Specify: WHITE 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PLUMBER PLUMBING UNKNOWN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ٥ CHARLES WILLIAM LEWIS SR. PAULINE ANN JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a item 27 PAULA J. WILLISON/EXECUTOR 10303 CATHELL ROAD, BERLIN, MD 21811 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it nent of 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place CREMATORY OF DELMARVA 4 Donation 5 Other (Specify) 12/27/11 DELMAR, DELAWARE 21. Signature of Puneral Septice Licensee 22. Name and Address of Facility any HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part . En er the disease, or complications that caus shock, or heart failure. List only one cause on each line eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Records. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Who 24a. Was an perform 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 1 atural 5 Pending 1 Yes 2 No pletely filled in by the Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Number Practitioner: To the board of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29c. License number 29d. Data signed (Month, Day, Year) မ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHORE DR, SALISBURY MD 2/804 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Items 28a - Pr Mary 923, 0 - Pr 126 health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1625 Michael 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Peninsula Regimal Medical Center Nicomico alisburu If Under If Under 24 Hrs. 8. Date of Birth Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Hours Min 219-98-5284 **Director** 1 **X** M 2 □ F 2-15-1975 36 Illinois Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Tes 2 X No Pittsville MD Wicomico ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n USA 21850 34782 Sandyfield Road items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or ite Medical Examiner Black, White, etc by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Tire Sales Retail Sales Manager 12 traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ္ Hankey Jayne Lane and is **m** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 36677 Main Street, Millsboro, Delaware 19966 <u> Jayne Levinson - Mother</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Delmar, Delaware Crematory of Delmarva 12-28-2011 Bounds Funeral Home 21. Signature Funeral Service Licenses 22. Name and Address of Facility 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one ca Immediate Cause (Final disease or condition Priset and Death Ph sician/ WOUND TO THE Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to in reduce cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and -trans CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): -burial-1 attending physiciar Physician/Medical certificate be 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) use 23b. Was decedent pregnant 23d. Date of delivery Box ρ in the past 12 months? Day Month Yes 2 No g 🗌 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ EPRESSION Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 25. Was case referred to medical exampler?

1 Yes 2 No Hospital or Attending Physician; of Vital Be 26. Place of Death (Check only one) Hospital: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 12/22/2011 10:49 pm Division 1 Yes 2 No Subject shot self within 24 hours after death

To the Funeral Director: A
completely filled in by the f Suicident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Rear Deck of Mother's 281. Location (Street and Number or Rural Route Number, City or Town, State) 36677 Main Street, Millsboro, Delaware determined 4 Homicide Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, DECEMBER 25th, 2011 254048 5TC address of person who completed cause of death (Item 23a) (Type, Print) ACEK M. MALIK MOPHD, 540 SNOW HILL RD, SALISBURY MD, 21804 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

3

29 2011

State of Maryland / Department of Health and Mental Hygiene 2 [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 25, 2011 12:21P. M Leonard L. Lourie Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3142 Gracefield Road, MG505 Silver Spring Prince George's . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F 91 Months Days Country) Ohio 216-44-9064 Hours 0212nth 304 1920 Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director ems 23a or 28a-f sh r must be notified a Maryland | Prince George's Silver Spring 1 ☐ Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3142 Gracefield Road, MG505 20904 United States 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give It Yes, Give Year or Dates. 1943-1946 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h, Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Patent Attorney Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F ပ William Lourie Isabel Guthman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Thelma Lourie -wife 3142 Gracefield Road, MG505 Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) King David Memorial Gdns. 12/28/2011 Falls Church, Virginia 21. Signature of Funeral Service Licenses Bohald W. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Cardiac Arrhythmia Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Parkinson's Disease Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No or Attending Physician: Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 1 No Other: 4 Nursing Home 5 PA Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending ours after death.

neral Director: A
filled in by the fu death 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Hospital Medical Certifying Physician: To the be 29a. Certifier To the Hosp within 24 hou To the Fune completed fil of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

be best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the basis of ctioner: To the Certifying Nur 29b. Signature and title of certific 29d, Date signed (Month, Day, Year) D24035 December 27, 2011 12+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugenio Machado, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) State **DEC 28 2011** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 23 2011 Physician/ 9:54 AM Dec Medical or Location of Death **Examiner** 4c. County of Death Boltinae **Funeral** Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign $Ju^{(Me^{nth}}1^{Dey}, ^{Year})941$ CountryMalaysia Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director Greenbelt Prince Georges Maryland 1 ☐ Yes 2 🖾 No o. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a Funeral 20770 7204 Mandan Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces Black, White, etc. marked other than "natural", or 1 Never Married 2 Married Completed by 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Asian 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Grocery Store Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sow Hoong Haw Chan Kai Law .. Page 1 and 2 should tment of Health and M tant: If item 27 is man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $7204\ Mandan\ Road$, Greenbelt, MD 20770Grace W. Law/Wife Date 27, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other place Dec. 2 20<u>11</u> 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 22. Name and Address of Facility ins Funeral Home Inc. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ 12 Martin disease or condition Medical resulting in death) Examiner Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine physician and the burial-flags The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day signed by the at d be detached fo Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Tyes Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 No Other: 1 Yes မှ 1 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

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ST. Balline, UD 21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death Registrar Amend#31 . PerVRPC1-3-2012cr 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Radcliffe MacCormack December 28. Sylvester 2011 8:20 A. M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth (Month, Day, January 9. Birthplace (State or Foreign Country West Africa Sierra Leone, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 1940 Funeral 1 **X** M 2 □ F Months Hours Min 577-11-7140 71 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shovnotified at 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director 1X Yes 2 □ No Silver Spring Maryland Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? West ral", or items 23a or Examiner must be Funeral 20903 520 Beacon Road; Apt. A Sierra Leone, Africa Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc ģ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 within 72 hours after Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany once. Elementary/Seconday (0-12) College (1-4 or 5+) Security Officer Security Agency 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hannah Egertona Sawyerr Eustace Gilbert MacCormack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 Beacon Road; Apt. A; Silver Spring, Maryland 20903 Nancy Bridges MacCormack (Wife) Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 14, 2012 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery Adelphi, Maryland 22. Name and Address of Facility R. N. Horton Company Morticians, signature of Funeral S Lange Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ Advances disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to lor as a consiquence of if any leading to immedicause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 1 Yes 2 9 Unknown been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? iniury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number M.O. 121-17 06929 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1010 20907 100 Med 101 32. Regi trar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:00 A 2011 Medical Alice Mae McCree December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glenn Dale Prince George Capitol Caring Hospice 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 1 🗌 M 2 😾 F 579-32-4222 91 12/20/1920 North Carolina Usual Residence of Dec ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No DC Washington 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 4503 4th St. NW 20011 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. or þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify "natural", 3 Midowed 4 Divorced Completed who aygiene. Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with th and Mental Hygien 7 is marked other th CMP Telephone Comp. <u>Cafeteria Worker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ traumatic Roy McCain Annie Funderburk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important. If item 27 is any injury or other trau 11405 Trillum St. Mitchellville, MD 20721 Richard McCree/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 12/31/2011 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home Signature of Funeral Service Lo an 3401 Bladensburg Rd. Brentwood, MD 20722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician Acute Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Arterial Hypertension Sequentially list conditions, Examine Due to for as a consequence of if tany, returning to immediate cause. Enter Underlying burial-transi Cause (Disease or injury that initiated events Chronic Renal Failure Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Multiple Myeloma Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 🙀 No detached P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? hin 24 hours after death.

the Funeral Director: After this certificate 1 Yes 2 No 1 Yes 2x No or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1X Natural 5 Pending work 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu e and title of certifi 29d. Date signed (Month, Day, Year) 29c. License number 12/29/2011 MD 5679

State Registrar

R 20

DHMH 17 Rev 06-2011

Enrique A.

JAN 0 3

Robles, MD 10 Irving St. NW Suite 421 Washington, DC 20010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registair's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Pamela Ernestina Moore-Carroll 28 December 2011 9:20 A. M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges North Brentwood 3907 Windom Road 1955 Year) 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Days Months Hours 1 M 2 X F 56 Panama 579-25-6739 September 19 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Prince Georges North Brentwood Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20722 Republic of Panama 3907 Windom Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Bace - American Indian 11. Marital Status Armed Forces? 1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married 1X Yes 2 No Specify: Panamanian Latino If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Georgetown University mentary/Seconday (0-12) College (1-4 or 5+) 12th grade Environmental Services Worker Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Zillah Aird Barr Erick Moore 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3907 Windom Road; North Brentwood, Maryland 20722 Reginald Christopher Carroll, III 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State Jan.7,2012 4 Donation 5 Other (Specify) Brentwood, Maryland Fort Lincoln Cemetery Signature of Funeral Service 17cen 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Metastatic Neuroendocrine Carcinoma disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events Year of death? 🛣 Unknown gs available

Physician/ Medical **Examiner**

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Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

after death filled in by 24 hours a

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Department of Important: If any injury or once.

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permit. Page 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

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Funeral

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Physician/Medical Examine þ Be Completed Medical Certificate: To

resulting in death) Last	Due to (or as a consequence of).		
	d		
F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day
Part II. Other significant conditio	ns contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause o
		24a. Was an autopsy performed?	24b. Were autopsy finding prior to completion of death? 1 Yes 2 No
5. Was case referred to medical	26 Place of Death (Char	ok antu ana)	

		performed? 1 \(\text{Yes} \) 2 \(\text{N} \) No 1 \(\text{Yes} \) 2 \(\text{N} \) No
25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check of Inspiral I	nly one) a 5 X Residence 6 □ Other (Specify)
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? M 1 Yes 2 No	d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
	ician: To the best of my knowledge, death occured at the time, date and place, and o	

only one)	3 Certifying	Nurse Practioner: To the best of my	knowledge, death	occurred at the time, date and place, and	due to the cause(s) and manner as stated.
b. Signature	and title of certifier	Rougetchou,	mo	29c. License number	29d. Date signed (Month, Day,

29d. Date signed (Month, Day, Year) 12/28/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 600

Joselyn Kouatchou; M.D.; 4041 Powder Mill Road; Calverton, Maryland 20705

State Registrar 31. Date filed (Month, Day, Year, 32. Registra 's Signal JAN 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ Moses 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** REGIONAL HICOMICO Medical 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Director 218-20-8817 1 **№** M 2 🗆 F 84 Dec. 9 Virginia items 23a or 28a-f show her must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Somerset Westover Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A 8120 21871 Woods ane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Examiner Black, White, etc. 0 Completed by 1 Never Married 2 Married If Yes, Give 1950-1952 Year or Dates. 21215-0036 1 ☐ Yes 2 👺 No Specify. Specify: Black "natural" 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 7 feath and Mental Hygiene. item 27 is marked other than other traumatic event, the M marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Univ. of MD. Fastern Shore House Keeping 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jones moses Viola evin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt 26 30510 Princess Ame, MA 21853 moses-Lottie Notters other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. Page 1 PBurial 2 Cremation 3 Removal from State 12/31/11 Pocomoke 4 Donation 5 Other (Specify) Tindley's Chapel Cometay 21. Signature of Funeral Service Licensee Anthony E. Ward Fit 30639 Hampden Princess Anne, MD, 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ infarction Myocardial disease or condition resulting in death) Medical Examiner Cevelore vas culcul acciden Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-transit ferkere Acarte renoi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 68760 IF FÉMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 068222 12-25-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST., SALISBURY, MD , LOOE CAPPOLL Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARGUERITE Hudson Mariner Month Year 4:00 A 2 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner burg Hospice muco If Under 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe Age (In yrs. last birthday) **Funeral** Month, Day, Year) Country) 218-16-7450 **Director** 1 □ M 2 🗙 F 89 Yrs. Nov. 22,1922 Virginia Usual Residence of Dece 28a-f show 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No Salisbury Md. Wicomico 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? Funeral 21801 United States 430 Somerset Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Decedo... Armed Forces? Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White MargueriteHMarine 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Clerical 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျ Department of Health and Ment. Important: If item 27 is marked any injury or and Clara Leslie Hudson Earneille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nadine Cavey-Step-daughter 1020 Tyler Ave. Salisbury, Md. 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Allen, Md. Allen Cemetery 12-23-2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, Md Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failt Immediate Cause (Final Physician/ A SCUD disease or condition resulting in death) Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death been signed by the sahould be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2 autopsy performed? Yes No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of Cal Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation pletely filled in by the 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signaty e and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D63199 12/2/11. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALIBBURY

State

Registrar

DEC 27

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

ion/	For State Registrar 1. Decedent's Name (First, Middle,	Last)		Cen	tificate of E	Death		Reg.	No. 2	O	1, 3 3 3. Time of Death
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iner	4a. Acility Name (if not institution, of	give street and number) Gwnas Mé	dica	Park	4b. City, Town, or	Location of	Death		4c. County	y of Death	nico
al	5. Social Security Number 6	6. Sex 7. Ag	e (In yrs. las:	t birthday)	If Under 1 Year Months Days	If Under 2 Hours		ite of Birth onth, Day, Yea	ar)	9. Birthpla Countr	ace (State or Foreigi
r	218-50-1039 Usual Residence of Decedent	1 🗆 M 2 ื F	65	Yrs.			07,	/08/194	46	Mary	vland
ctor	10a. State 10b. County			Town or Loc						10	ld. Inside City Limits 1 ☐ Yes 2 X N
Director	Maryland Wicon 10e. Street and Number	nico	Sa	lisbu	10f. Zip Code			10g.	Citizen of	What Countr	
Funeral	7547 Titleist	Drive			21801				USA		
by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent I Armed Forces? 1 Yes 2 X		13. W	as Decedent of Hi Yes, specify Cuba	spanic Origi n, Mexican,	in? (Specify Ye Puerto Rican,	s or No- etc.)		ce - America ck, White, et	
	3 Widowed 4 X Divorced	If Yes, Give Year or Dates.	INO	1	☐ Yes 2 🔀 No	Specify:			Specify	/: Wh	ite
Completed	15. Decedent (Specify only highest			(Give k.	ent's Usual Occupa ind of work done of NOT use retired)	ation Juring most (of working	166	. Kind of E	Business/Indu	ustry
	Elementary/Secondary (0-12)	College (1-4 or 8	5+)		retary			I	Exter	minati	.ng
To Be	17. Father's Name (First, Middle, La. Ralph B. Whit	,					r's Name <i>(First,</i>		en Surnam	ne)	
	19a. Informant's Name/Relationship Lynn Messick/s	(Type, Print)		19b. Mailing	g Address (Street a	and Number	or Rural Route	e Number, City	or Town, 3	State, Zip Co	ode)
	20a. Method of Disposition 1 Burial 2 Cremation 3		cer	metery, crem	sition (Name of atory or other plac		Date 12/30/2			- City or Tov	
olice.	4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Euneral Service Lic		Sall	22	r Cremato Holloway° 501 Snow	Puner	al Hom	e Profe	essio	nal As	sociatio
1	23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition			Do not enter					1.		Approximate Interval Between Onset and Death
al er	resulting in death)	Due to (or as	a conseque								
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce of):							
<u>a</u>	that initiated events resulting in death) Last	Due to (or as a consequence of): d.									
Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal of	death 3 🗌	Ectopic pregnanc Other (specify)	у				ate of deliver	'Y Day Year
by	Part II. Other significant condition	s contributing to death b	out not result	ting in the ur	nderlying cause giv	en in Part I.	23				e cause of death?
Completed							2-	4a. Was an autopsy		prior to com	sy findings available
								performed Yes 2		death?	2 No
To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital:	ent 2 \square FI	R/Outpatient	Othe	12"	sing Home 5		s ∈ □ Oth	per (Specify)	-
	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investiga	28a. Date of inju (Month, Da	iry 2	8b. Time of injury	28c. Injury work	at	28d. De	escribe how in			
Certificate:	3 Suicide 6 Could no 4 Homicide determin	ot be		e, farm, stre	et, factory, office			cation (Street ty or Town, St		per or Rural F	Route Number,
Medical	(Check 2 Medical Sx	Physician: To the best of aminer: On the basis of e burse Practitioner: To th	xamination a	and/or investi-	gation, in my opinio	n. death occ	curred at the time	ne, date and pla	ace, and du	le to the caus	se(s) and manner sta
	29b. Signature and title of dertifier				29c. License	number		29d.		ed (Month, D	
					1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruth Townsend Morris 1219 M DEC 20 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner LENINSHUN REGIONAL 544136419 MEDICAL HICOMICO If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 215-44-6194 **Director** 1 □ M 2**X** F 64 01/23/1947 Maryland 28a-f show aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 No Maryland Wicomico Salisbury ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 201 Craft St. 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 0. þ 1 Never Married 2 X Married 1 Yes 2 XNo If Yes, Give 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Retail Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Townsend Sr. Mary Belle Phillips 19a. Informant's Name/Relationship (Type, Print)

Crystal Godwin/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 201 Craft St., Salisbury, MD 21830 20b. Place of Disposition (Name of cemetery, crematory or other place Springhill Memory Gardens 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 12/23/2011 4 Donation 5 Other (Specify) Hebron, MD 24. Signatur of Funeral Service Licenses 22. Name and Address of Facility Home Professional Association any 12 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician/ disease or condition resulting in death) Stay weint Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami use as the burial-transit Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be types ten gron 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day ed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 1 Yes 2 46 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the F within 2. To the F

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

29c License number

DO04/21/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20 Physician/ Dicember MANDICH 5457 M 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PERRY VA MARYLAND HEALTH CARE SYSTEM Point Ceci Social Security Number If Under 1 Year If Under 24 Hrs. ME KNOWN +OPHSILIAN! MAN dich, BOARS **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Country) Director 210-20-7332 83 Usual Residence of Decedent or 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 520 Old <u>Elk Neck Road</u> U.S.A. 21901 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Hygiene. other than "natural", or 1 Never Married 2 X Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify. Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with.

and Mental Hygiene

7 is marked other th 4 Designer Steel permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viecslav Mandich Olga Dorothea Ivan Platzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Mandich / Wife 520 Old Elk Neck Road, North East, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State \square Burial 2 \square Cremation 3 \square Removal from State AME 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 12/21/2011 Hanover, Maryland 21. Signature Funeral Service 22. Name and Address of Facility Anatomy Gifts Registry MD 21076 7522 Connelley Dr., Ste. P, Hanover, 23a. Part 1. Enter the Nee'se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Kenal Insulficience disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Diabetes Mellitus Type 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Dus to (unas a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last and tran Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No or Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural Accident work? 5 Pending 24 hours after death. Funeral Director: A 2 🗌 No Investigation 6 Could not be the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi only one) 29c. License number 29b 29d. Date signed (Month, Day, Year) H0054439 December 20,2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) incent A Giminaro, DO - VAMoryland Healthears System Perry Point MD 21902 31. Date filed (Month egistrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State of Waryand / Department of Fleath State Registra AMEND#23a(a-c)perMD, 1/6/12; EMW, McCo Certificate of Death , Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 12/18/2011 KATHERINE MARIE MATTHEWS 11:32 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Director 219-78-8473 1 □ M 2 □**x** 52 11/14/59 MD ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 14120 Weeping Willow Dr., #12 20906 U.S.A ed other than "natural", or items event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black White etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 TNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 XDivorced Specify: Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b, Kind of Business/Industry (Specify only highest grade completed) life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other the Montgomery General Hos Nursing Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard W. Thornton Corrie Louise Lee other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s.
Department of Health a.
Important: If item 27 is any injury or ... Clifton D. Lee/Brother 18556 Brooke Rd, Sandy Spring, MD 20860 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Ash Memorial Cemetery 12/29/2011 Sandy Spring, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signature Funeral Service Lice se 246 N. Washington Street, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
ediate Cause (Final
Cardiopulmonary Arrest Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Fulmonary Edema Fptic Shock Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque 1-traosit that the death certificate be executed Acute Renal Failure that initiated events resulting in death) Last Due to (or as a consequence of) physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as t nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Dav Pregnant at time of death Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s perform death? 2 🗌 No Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🕅 No ည 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft
completely filled in by the fur 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D65305 12/18/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nabila Khan, 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, State DEC 28 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ^{Day} 2011 John L. Matthews Dec. 1:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6604 Virginia View Court Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Nov. 22, 1920 **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Hours Min. 1 DKM 2 DF Months Ohio Director 579-01-7336 91 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Md. Montgomery Bethesda 1 Yes 2 No 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6604 Virginia View Court 20816 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? 9 Black, White, etc. à 1 Never Married 2 X Married 1 DxYes 2 No If Yes, Give 942-1945 Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify. "natural", White 3 - Widowed 4 - Divorced Completed If Hygiene.

Other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed Self-employed Elementary/Seconday (0-12) College (1-4 or 5+) Home Builder Construction Be 17. Father's Name (First, Middle, Last, anould be filk th and Mental h 18. Mother's Name (First, Middle, Maiden Surname) ည James A. Matthews Anne Marie Yeager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Barbara Cannon Matthews/Wife 6604 Virginia View Ct., Bethesda, Md. 20816 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 a Department of I Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'1 Cem | Jan. 19, 2012 Arlington, Va 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses MØ0828 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. P . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition Onset and Death Physician/ End Stage Atherosclerotic Cerebrovascular Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Dusito (or as a consequence or, If any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and Exami Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav signed by the a Id be detached f 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by the Hospital or Attending Physician: The law requires hin 24 hours after death. the Funeral Director: After this certificate has been sign mpleted filled in by the funeral director, page 2 should be mpleted filled in by the funeral director, page 2 should be Records, Completed 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 2 K No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident
Suicide 2 \square No 2 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours at To the Funeral D completed filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signatu d title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Division of Vital

ress of person who completed cause of death (Item 23a) (Type, Print)

✓ 32. Registrar's Signature

Gary Raffel, D.O.,

DEC 28 2011

31. Date filed (Month, Day, Year)

45839

5413 W. Cedar Lane #203C, Bethesda, Md. 20814

December 22, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 12/26 2011 Vivian Josephine Nielsen Physician/ 22:45 м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester 7. Age (In yrs. last birthday) 96 yrs If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 475-24-6228 1 □ M 2 🕱 F (6971571 5°ar) MN Yrs Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** St. Paul MN Ramsey Yes 2 No 10e. Street and Number 1415 Almond Avenue 10g. Citizen of What Country? 10f. Zip Code 55108 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Domestic Homemaker To Be 18. Mother's Name (First, Middle, Maiden Surname)
JOSEPhine Olson 17. Father's Name (First, Middle, Last)
Welbec Parsons 19a. Informant's Name/Relationship (Type Print)
Charlotte M. Hall / 195 Mailing Address (Street and Number Chico, CA 95926, Zip Code) Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 1/3/2012 Minneapolis, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Formal Service Licensee Victor P. Doda ^{22. Name and Address of Facility} Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230 Oras 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day Year Pregnant at time of death signed by the at d be detached for 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 XNo has death?
1 Yes 2 No certificate Division of Vital 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA No the noop within 24 hours after death.

To the Funeral Director. After this in the funeral director and funeral directors are funeral directors. 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury Natural 5 Pending ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Nielsen Medical 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signati 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) reeuwou T 3 2012 egistrar's Signature State parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23, 2011 Physician/ Month Nitsios Mary 2:20a M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours (Month, Day, Year) 096-20-9225 **Director** 86 Yrs June 08,1925 New York Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2X No Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? rms 23a or Funeral 11205 Rock Road 20852 U.S.A. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify Completed 3 X Widowed 4 Divorced White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, f Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Theodore Stamos Anna Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aspasia Koumpouras - Daughter 11205 Rock Road, Rockville, Maryland 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/28/2011 Silver Spring, Maryland Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Fundral Pervive Librasee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00209 Jarrey 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Ph_sician/ CONLES LLC ART disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate Certificate: To Be Completed by Physician/Medical Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 1 ☐ Yes ∠- 9 ☐ Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed 1 Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Yes 1. Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1-Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30, UND 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive, #206, Rockville, Maryland 20850 Truong Bao, M.D.,

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

DEC 28 2011

32. Registrar's Signature

11-09770 Jake Owen Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifica	te of l	Death	Certificate of Death Reg. No.								
Physicia ⁻∹ical Exami	an/	Decedent's Name (First, Middle,La	Jake						. Date of De Month Decembe	Day er 28, 20		1	ime of Dea 536 hrs	ith	
		4a. Facility Name (if not institution, gir Johns Hopkins Hospital	ve street and number)			. City, Tow Baltimoi		cation of	Death		4c. (County of D	eath		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min. 1. 1. 1. 2. 2006								D/YYYY) 9. Fo	Birthplace reign [V	1ary La	and		
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nd show any ice.	_	10a. State 10b. County Maryland N/A	10c.	City, Town or Balti										. Inside Cit X Yes 2	•
he Maryland or 28a-f show	Director	10e. Street and Number 430 East Randal	1 Street			10f. Zip Co	1230)			10g. Citize	en of What 0			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever Armed Forces?		If Yes	Decedent of s, specify C	of Hispar uban, M	nic Origir Iexican, F		cify Yes or N ican, etc.)	- 1	4. Race - Ar White et Specify: Am	merican II		ж,
s after iral",	þ		d If Yes, Give Year or Dates:	160 D		Yes 2 🔀			nd of wo	rk done		nd of Busine			
2 hour	Completed	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)			st of workin					(OD, Kil	nd or busine	ssamuus	d y	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Į m	0			St	tudent						Educat	ion		
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212' uld be: Mental marke	o Be	James 19a. Informant's Name/Relationship (Owen 196.	Mailing /	Address (Street ar	nd Numb	SU er or Rui	ISAN ral Route Nu	ımber, City	LUM y or Town, S	tate, Zip	Codeb 1	30
MD 1d 2 should be and 3 mm 27 is a numatic			other	43	30 Ea	ast Ra	anda	11 S				ore, M			.50
re, rand f Healt f Healt f item		20a. Method of Disposition	Removal from State	20b. Place of	Dispositi y or votbe	ion (Name o	of cemet			Date	20c. Lo	ocation - Cit			
Pages Pages nent of		1 X Burial 2 Cremation 3 Removal from State Du Farnery of Variable 4 Donation 5 Other Specify: Memorial Gardens 1-6-2012 Timonium											aryla		
Baltimore, permit. Pages 1 an Department of Hea Important: If iter		Paul NK	ignature of Funeral ervira licensee 22. Name end Address of Facility Ruck Towson Funeral 1050 York Road Towson, Maryland										1 Hon 212	ne, In 204	nc.
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									k, or heart		oproximate etween On	set and	
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		Sequentially list conditions,													
	Examiner	if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated	Due to (or as a consequent Due to (or a) consequent Due to (or												
760, icate be executed physician and the burial - transit		events resulting in death) Last	<u> </u>	——————————————————————————————————————									\perp		
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18760, tificate be ing physic as the bur	M/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth		Feta	l death	3	Ectopic _I	pregnanc	су		Date of del Month	Day	Ye	ear
of Vital Records, P.O. Box 68760, sing Physician: The law requires that the death certificate be After this certificate has been signed by the attending physici funeral director, page 2 should be detached for use as the buri	Physician/Medical	1 Yes 2 No 9 Unknow	4 Pregnant at time of death 5 Other (Specify)												
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Division of Vital Records, rate of Attending Physician: The law requirements and reference of the this certificate has been sited in by the funeral director, page 2 should be	ä	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investiga	28a. Date of Injury (Month, Day, Year) Dec 28, 2011	1445		· · I		2 🗸 1	ID	assenge			on		
Divisite or At ours after de filled in by	Certification:	3 Suicide 6 Could no determine	t be 28e. Place of Injury -			, factory, of	fice build	ding, etc.		8f. Location or Town, 83 @ I-695				toute Numb	er, City
o the Hospi ithin 24 hou o the Funci empletely fi	의 문화 등 경우 기계 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannon one one one of the cause(s) and mannon one of the cause(s) and the cause(s													use(s)	
To with	Me	29b. Signature and title of certifier					icense n					ate signed ember 29		Day, Year)	
		30. Name and address of person who													
		Donna M. Vincenti, MD	Assistant Medical E		900 V	N. Baltin	nore S	treet, i	Baltimo	ore, MD 2	1223				
St Regis	tate	31. Date filed (Month, Day Year) JAN 1 7 2012	32. Registrar's S	- 11	led										

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death atruc Physician/ 515 PM Medical 4a. Facility Name (if not institution, give street and number) or Location of Death **Examiner** INTON Jary Jane If Under 24 Hrs. . Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) Country) **Director** 1 M 2 🗆 F 1-5-1936 VIRGINIA 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director vitland notified 28a-f Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n side 0 hady Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc ō Completed by 1 Never Married 2 1 Yes 2 If Yes, Give ₩arried 2 Baltimore, Maryland 21215-0036 1 Yes 2 Ho 3 Widowed 4 Divorced "natural" Year or Dates er than "natur the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) abor BUILDING -NSINBER ath and Mental Hygie
27 is marked other
r traumatic event, the other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ INWOOD ITOILS UECH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2409 Shrdyside Avenue Sui Eland WO 20746 wife Patruck 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ō eremation 3 🗌 Removal from State Department of Important: If any injury or once. Riverdale Kivendale, IUD -2-2012 Other (Specify) 22. Name and Address of Facility Wiseman Funeral Home co135 7527 Old. Ferry Rd Clinton Hexandria 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duki to (or as a nonsequence of, the attending physician and shed for use as the burial-transit Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No detached 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nonknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 2 N Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DODS 5314 12.30.2011 cause of death (Item 23a) (Type, Print) 34LVBS76R OKONICWO HIL RD, 518 807, Oxon OXON

DHMH 17 Rev 06-201

State

Registrar

31. Date filed (Month, Day, Year)

3 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Queen Mattie Jewe1 2011 December 9:18 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2750 Lorring Drive #304 Forestville Prince George's 8. Date of Birth (Month, Day, Year, Dec. 3, 1 Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** Hours 1 □ M 2 😿 F 578-48-8698 77 Director Washington, DC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director District of Columbia 1 X Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20032 866 Yuma Street, SE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Black Specify: Completed 3 🖾 Widowed 4 🗌 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than ' Elementary/Seconday (0-12) 12 years College (1-4 or 5+) Private Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jewel Soloman William Moore 19a. Informant's Name/Relationship (Type, Print) Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2722 Lorring Drive #303 Forestville, MD 20747 Ladeda Queen Brooks/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Jan 3, 2012 Landover, Maryland 4 Donation 5 Other (Specify) Harmony 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. lewar 4001 Benning Road, NE Washington, DC 20019 Patr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Acute Cerebral Accident Medical resulting in death) Due to (or as a consequence of) Examiner Arterial Hypertension Years Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a confinguisher of: Hyperlipidemia Years law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month After this certificate has been signed by the a funeral director, page 2 should be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 X No prior to completion of cause of death? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director, After this certificate h 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Daughter's Hospital Other: 4 Nursing Home 5 Residence Other (Specify) Home 2X No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work 1 Tes 2 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only of Contribing Nurse Creationer To the best of my Incollege of oth commod at the time, date and place, and due to the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year, December 31, 2011 MD5679 DC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Enrique Robles, M.D. 106 Irving Street, NW #421 Washington, DC 20010 32. Registra s Signa State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. D2011 27, Dorothy S. Cohen Rosenberg 1422 hrsM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Worcester Atlantic General Hospital Berlin 5. Social Security Number 7. Age (In yrs. last birthday) 91 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Min 1 □ M 2 💢 F Hours ^{Year)}1920 Washington, DC **Director** 578-12-3250 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Worcester Ocean City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7503 Coastal Highway USA 21842 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Smithsonian Exec. Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrea Gordon Morris Cohen permit. Page 1 and 2 should Department of Health and N Important: If item 27 is mal any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7503 Coastal Hwy., Ocean City, MD 21842 Marsha Howarth | Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12 30, 2011 Falls Church, VA King David Mem. Prk. 21. Signature of Maral Service Licensee 22. Name and Address of Facility 501 Snow Hill Rd. Holloway Funeral Home, P.A., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 ed by the attending p detached for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Year Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Probably 4 Unknown Completed 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes Vital Hospital or Attending Physician: Be 25. Was case referred to redical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this ot 27. Manns of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Division within 24 hours after death.

To the Funeral Director: After completed filled in by the fun Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) D53612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Berlin MD ZiP11 31. Date filed (Month, Day, Year) Registrar's Signatu

DHMH 17 Rev 7/2009

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month DEC \mathbf{P}^{M} JOSEPH ALPHONSO ROGERS 2011 6:36 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WRNMMC BETHESDA 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, 577-56-4056 69 Months Days Hours Min 1 **X** M 2 □ F Yrs Director Washington, DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Prince George's Yes 2 No Maryland Clinton ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be United States Funeral 11834 Sylvia Drive 20735 death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etcAfrican Armed Forces?

1 Y Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married þ Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: American "natural", Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Military (Army) Government 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be find of Health and Mental E: If item 27 is marked or other traumatic ev ည Mildred Z. Smith Arnett Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15414 Brinton Way Brandywine, MD 20613 Monica Robinson - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Maryland Vets Cemetery Jan 9, 2012 permit. Page 1
Department of Important: If it any injury or conce. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Den 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₹ııysiciaı# CARDIOVASCULAR DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last pue Due to (or as a consequence of) attending physiclan for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year 5 Other (specify) been signed by the a should be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 \square Yes 2 X No 3 \square Probably 4 \square Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate Yes 2 No Division of Vital 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 1 ☐ Yes __2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After (Month, Day, Year) 5 Pending Natural 1 Yes 2 No 24 hours after death Funeral Director; A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NE23260

Registrar

State

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WRNMMC,

20889 5600

BETHESDA,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

LINDSEY D ROSCHEWSKI,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rosen Eulah Ε. December 2011 1:00 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death $P \cdot G$. Renaissance Gardens at Riderwood Village Silver Spring 5. Social Security Number If Unde 9. Birthplace (State or Foreign Country) VA Year If Under 24 Hrs. Age (In vrs. last birthday **Funeral** 8. Date of Birth 1 □ M 200 Days $June^{\frac{(Month, Day, Year)}{21}, 1915}$ Months Director 217-05-1452 96 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD Silver Spring Montgomery 28a-f 1 Yes 2 No the 10e. Street and Number ms 23a or must be r ò 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 3122 Gracefield Road, #416 items be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify White "natural" Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper 12 Accounting event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental F is marked o permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evenonce. ပ Hector Keener Emma Virginia Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Keener/ Nephew 6805 Sierra Highway, Santa Clarita, CA 91390 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State Dec 30 4 Donation 5 Other (Specify) George Washington Cemetery Adelphi, Maryland 21. Signature of Funeral Service Licensee Name and Address of Fac Erancis J. Cel 500 University ins Funeral Home Blvd. W., Silver 23a. Part 1. Inter the disease, or complications that caused the path. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, than, leading to mineurate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exami that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialphysician **Medical** Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery the past 12 months? 3 Ectopic pregnancy į Month Pregnant at time of death 5 Other (specify) Day Year the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation, Cognitive Disturbance Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? this certificate 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital XX No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director. After completed filled in by the fune 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 3 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical X Certifying 29a. Certifie g Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examinet: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Chec ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only (29b. Signa re and t 29c. License number 29d. Date signed (Month, Day, Year) D24035 December 25, 2011 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) Eugenio Machado, 3110 Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day, Year, State **DEC 2** 8 2011

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia Medic		IVANETE (ORNELLA	S ROO	HA						Decen	ber	25,	2011	12:5	
Examin		4a. Facility Name (if		-						1	4c. County of Death				1.	
Frince and		Laure 5. Social Security N	Regi	6. Sex			ast birthday)	If Und	er 1 Year	JUPE	8. Date of Bir		-KIN		Seorge	
Funeral Director		212-37-79		1 \(\text{M}	îXĪ ⊏	55	Yrs.	Months		Hours Min.	04/24/	1956	5	Braz	ntry) Z11	roreign
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12 sho alth an 27 is r trau		Vera Orne			,		9800	Leat	her l	Fern Ter	r., #30]	L, Mc	or Town, State, Zip Code) 20886 Montgomery Village,			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location									ocation -	- City or T	own, State			
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₽ ½ ₽ <u>§</u> 5		29b. Signature and	title of certifier	Fac	PTT D		_	2!	9c. License				_		Day, Year)	11
•		30. Name and addr	ess of person	who comp	leted cause of			Print)	عال ا	57216		Jan	DIL.	cen	26, 20 Road	TT
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month /2 Physician/ Sisco 21351 Karen Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MediCAL REGIONAL HICOMICO SALISBULY ISULA 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) **Director** 1 🗆 M 2 💢 F 6 oct. Muryland show 10d. Inside City Limits 10c. City, Town or Location notified at Director 28a-f 1 X Yes 2 ☐ No Somersel Princess Anne Maryland 10e Street and Number 10g. Citizen of What Country? ms 23a or must be r 10f. Zip Code Funeral 21853 Pars 1.5. Lane Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Tyrs. callege 12th grade omputer Specialist Verizon $\mathbf{B}_{\mathbf{e}}$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilbert L. Johnson Evelyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Renae Corbin - Daughter <u> Sam</u> Bowlan 11264 Princess Anne, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rematory of Delmarra 12/30/11 Delmar Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony E. Ward F.H. Hampden Ave, Princess Anne mi 2853 Wa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opeet and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any least state of the cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Year Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No certificate 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Yes Other: မ 1 🗶 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practifioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29c. License number 1005 9831 dress of person who complet d cause of death (Item 23a) (Type, Print 30434 MT. VEINON RD

State Registrar Brett

HOFMANN

M.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ \mathbf{A}^{M} Helen M. Starro December 2011 5:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing & Rehab Center <u>Berlin</u> Worcester Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 - M 2 XF Months 7-7-1925 Director 202-16-4827 Hazelton, Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits 1 XYes 2 No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13032 Wilson Avenue, Unit 21842 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ You If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. SpecifWhite 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Door Greeter Wal-Mart Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ <u>John Chura</u> Anna Silock 19b. Mailing Address (Street and Number or Rural Route Number, City or Tawn, State, Zin Code) Naples, FL 14895 Pleasant Bay Lane, Unit 5203 19a. Informant's Name/Relationship (Type, Print) Mary Balun/Daughter 14895 Pleasant Bay 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 1-3-2012 Dover, DE Cremation, 22. Name and Address of Facility 917 W. Isabella St. 21. Signature of Funeral Service License Bennie Smith Funeral Home Salisbury.

23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cardiac property arrest, and the such as Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ # Medical ue to (or as a consequence of) **Examiner** Sta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Certificate: To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending n 24 hours after death.

e Funeral Director: A bleted filled in by the fu 1 🗌 Yes 2 🗌 No Investigation Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hours To the Fune completed file 29a. Certifier only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R 135131 December 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennie SAVAGE, 9715 Healthway Dr, Berlin, MD 31. Date filed (Month, Day, State egistrar's Signatu Registrar

Helen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Physician/ Simms Thomas James 8:03 P M 12 2011 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COMIC 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, yrs. last birthday) If Under 1 Year If Under **Funeral** Min 216-38-7513 1 X M 2 D F 70 Director 10/14/194 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland hjury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 K No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 21.804 USA 3566 Pocomoke Road Page 1 and 2 should 1e filed within 72 hours after death thrent of Health and Mental Hygiene.
 House 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. ð 1 Never Married 2 Married 1 X Yes Simms Simms Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Army Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver Be 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Anna Dryden Thomas Norman Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jamie Gilmore/Daughter 31152 Morris Leonard Rd, Salisbury, MD 21804 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Anatomy Registry ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/31/2011 Hanover, MD 4 N Donation 5 Other (Specify) Europe Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 per Depa Impo any ii Romanon CFSP Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastalic Physician/ Cancer disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to include cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or) by the attending physician and ached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death g Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed been si should I 24a. Was an . Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy death? this certificate No No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Hopoce 2 No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence Director; After the in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of at the Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? Natural 5 Pendina Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I only one 29d. Date signed (Month, Day, Year) 29b. Signal and title of certifie 29c. License number 1063199. 2/12,

Registrar
DHMH 17 Rev 7/2009

State

'NO

YOG-EU H
31. Date filed (Month)

SHORE

DR.

SALISBURY, MD.

address of person who completed cause of death (Item 23a) (Type, Print)

3

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 19, Gladys В p_{M} Stewart December 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 28656 Ocean Gateway Salisbury Wicomico . Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday **Funeral** 217-10-2450 Director 1 🗆 M 2 🗶 F 98 09/24/1913 Maryland Usual Residence of Deceden 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗌 Yes 2 🕱 No Maryland Wicomico Salisbury 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? must be Funeral items 23a 28656 Ocean Gateway 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Never Married 2 Married Yes 2X No Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black "natural", 3 X Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeper State Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unknown) Arintha Burris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28656 Ocean Gateway, Salisbury, MD 21801 Department of Health ar Important: If item 27 is any injury or other trauonce. Gladys E. Stewart/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Green Acres Memorial 12/23/2011 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Signature of Funeral Service Li 23 Lewart dorfuneral Home by Holloway and Downey, PA Car 821 West Rd., Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ADVANCED AGE disease or condition DEMENTIA DECONDITIONING Medical resulting in death) Examiner ONGESTIVE HEART FAILURE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be KIONBY Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Dav Year Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 death? After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manuer of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Director: / Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 12-21 51 - 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOY MADARANG-LEWIS DIVISION S SALISKURY 1405 31. Date filed (Mc State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar Certific	ficate of Death	Re	2011	43151		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death		
	Medic	al	LOLLAINE M. Dearb	b. City, Town, or Location of Death		er 21, 2011	3;15 a⁄		
فمرر	Examin	er	818 Tressler Court	Salisbury		4c. County of Death Wicomico	>		
	Funeral Director		218-22-4873 1 M 2 X F 84 Yrs.	f Under 1 Year If Under 24 Hrs. Ionths Days Hours Min.	8. Date of Birth (Month, Day, 103/24/19	Year) Cour	place (State or Foreign htry) Yland		
	and show i at	ē	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits		
	Maryla 28a-f	irect	Maryland Wicomico Salisbury		_		1 🏿 Yes 2 □ No		
with the is 23a or 2	Funeral Director	10e. Street and Number 818 Tressler Court	10f. Zip Code 21801	-10	ng. Citizen of What Coul USA	ntry?			
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 Yes 2 No	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
Maryland 21215-0036	iin 72 houi ie. han "natu s Medical	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind life. DO Ni	t's Usual Occupation d of work done during most of work IOT use retred)	king	16b. Kind of Business In	·		
72	ed with Hygien Ither ti	Be C		1 Office Manage:	ne (First, Middle, Ma		=		
<u>lan</u>	l be filk fental l rked c tic eve	10			hy J. Rop				
, Mary	d 2 should alth and N 1 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Sharon Staib/Daughter 19b. Mailing A 1940	Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 940 Wild Wood Trail, Pocomoke City, MD 21					
Baltimore,	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetery, cremato Salisbury C	ory or other place)	Date 2 2/2011	20c. Location - City or To Salisbury,			
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licensee	and Address of Eachity all I Snow Hill Rd.	Home Prof ' Salisbu	essional A ry, MD 218	ssociation 04		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	1 1			Approximate Interval Between Onset and Death		
and a	Phylician Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	O reast Co	ncer	- 4	Onset and Death		
	Examiner								
	d it	Examiner	Sequentially list conditions, if any leading to immediate Due to lor as a consequence of cause. Enter Underlying						
	xecute n and al-trans	Exar	Cause (Disease or iinjury that initiated events c. resulting in death) Last Due to (or as a consequence of):						
2	ificate be executed g physician and as the burial-transit	Medical	d						
08/80	ertificat ding ph	_	HE FEMALE.						
. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours affer death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1	ctopic pregnancy ther (specify)		23d. Date of deliv	Pery Pear Year		
S, P.O.	iires that ti i signed by Id be deta	by	Part II. Other significant conditions continuiting to death but not resulting in the under	erlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?		
Records,	law requas beer e 2 shou	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of		
¥	n: The lificate or, pag		25. Was case referred to medical	26 Place of Dooth (Char		death? No 1 Yes	2/ No		
VITA	ysicia is certi directo	To Be	examiner? 1 Yes No Hospital: 1 Inpatient 2 ER/Outpatient 3	26. Place of Death (Chec	7	nce 6 Other (Specify	v)		
IO UC	nding Ph ath. r: After th e funeral		27. Manper of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury	28c. Injury at work? M 1 Yes 2 No	28d. Describe hov				
DIVISION	al or Atte s after de il Directo ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,		
	ie Hospit n 24 hour ie Funera bleted filk	Medical	29a. Certifier (Check Check 2 Medical Examiner: On the basis of examination and/or investigation on the basis of examination and/or investigation on the basis of examination and/or investigation of the basis of examination and/or investigation.	tion, in my opinion, death occurred a	it the time, date and	place, and due to the ca	ause(s) and manner stated.		
	To the within comp		29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month.	Dav. Year)		
	510		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	PUIZZZ C	MICRIES	12-21- 1,000 21	165		
	Stat	e	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	UX 1733 01	14304	2 2/	502		
	Registra		DEC 22 2011 Augus A James	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ي کي 55 2011 Darrow /Medical Facility Name (If not institution 4c. County of Death Examiner If Under If Under 24 Hrs. Social Security Number Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Director 84 227-24-2376 3-25-1927 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evant harman to a collect 1 Yes 2 □ No Director MD Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 402 Hammond Street 21804 Funeral USA hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐Yes 27 No Specify Specify. White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) es 1 and 2 should be file of Health and Mental H fitem 27 Is marked oth r other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Alonzo Moore Lucy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 834205th Street, Pasadena, Maryland 21122 Vickie Merli - Daughter Pages 1 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gd. 12-29-2011 Hebron, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service License 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical more Than 2 Due to (or as a consequence of): Examiner Encephalitis Due to (r as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last more than The law requires that the death certificate be executed Exami physician and s the burial-tran Adrenal in suft Due to (or as a consequence of) P.O. Box 68760, Physician/Medical betes attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Tract autopsy certificate 2 □ No Vital Extremity 1 ☐ Yes 2 **2** No 1 ☐ Yes Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital To the within 2

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael P. Buchn e 55 31. Date filed (Month, Day, Year)

michael O Buchuses

29b. Signature and title of certifier

and manner stated.

Registrar's Signatur

Deer's Head Hospital Center, Salisbury

29d. Date signed (Month, Day, Year)

State Registrar 29c. License number

00002038

VOID

CERTIFICATE

2011-43159

SEE

CERTIFICATE

2012 - 03475

Completed 2/10/2012

Bul

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Kelso Shipe December 2011 7:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 221 Booth Street Montgomery Gaithersburg If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. (Month, Day, Year) 577-28-8334 **Director** 1 **№** M 2 □ F 92 Washington, DC 04/12/1919 Usual Residence of Decedent or 28a-f show ıl Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director 1¥ Yes 2 ☐ No Gaithersburg MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States Funeral 20878 221 Booth Street death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status 2 No 1942-Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White 1944 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working of life. DO NOT use retired) ITESIGENT of Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Insulation Contracting C & R Insulation Co, Inc. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental His marked o ည Elise Wilson Frank Shipe permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print)
Bess Paterson Shipe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 221 Booth St. Gaithersburg, MD 20878 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Potometo, claration endther place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/30/11 Potomac, MD Methodist Cemetery of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signatu 5130 Wisconsin Ave. NW Washington, DC 20016 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Cancer of Prostate disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Chronic Renal Failure Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and difference as the burial transit the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and Dementia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Division of Vital Records, <u>Bipolar</u> Disorder Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 Yes 2 No Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2 XVo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending s after death. 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 12/27/2011 D0047330 NMBOL dwowns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #207 Rockville, MD 20852 31. Date filed (Month, Day, Year) DEC 28 2011 Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Charles Thomas Tawney 6:30 P 2011 26, December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Upperco 16541 Trenton Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6/24/1921 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 ☐ F 218-12-3258 Director 90 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov Director 1 □Yes 2 ¬No MD Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16541 Trenton Road USA 'natural", or items 23a 21155 Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 101 14. Race - American Indian, 11. Marital Status 1941-Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1945 Completed by 1 ☐ Yes 2 ▼No white Specify: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If Item 27 is marked other thr any Injury or other traumatic event, Image. C & P Telephone Telephone Foreman Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Reverdy Tawney Mary Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Whitcraft, daughter 20705 W. Liberty Rd., White Hall, MD 21161 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Church Trenton 12/30/2011 Upperco, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00741 22. Name and Address of Facility Eline Funeral Home Standa 934 S. Main St., Hampstead, MD 21074 semmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) COLIGORTIVE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760. physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division of Vital Records, P.O. sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**70**No 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 275No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of D ath 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOC242 Math 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Josue C. Laredo, M.D., 4041 Gill Ave., Hampstead, MD 21074 31. Date filed (Month, Day, Year) 32/Registrar's Signature State Registrar DEC 28 201

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 5 per fh 9923 1-26-12 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER MARY CONSTANCE TODD 2011 11:17 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT CHESTERTOWN CHESTER RIVER HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🛚 F Hours **5-**-20-6136 05/17/1926 MARYLAND **Director** 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 XYes 2 No MARYLAND KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21620 UNITED STATES 101 MORGNEC ROAD - N104 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 Divorced WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ AILENE MITCHELL WILLIAM A. SACKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOX 374 GALENA, MARYLAND 21635 JAMES WILLIAM TODD / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESTER CEMETERY 01/03/2012 CHESTERTOWN, MARYLAND 21. Signat A f Funeral Service Dicense FELLOWS, HELFENBEIN & NEWNAM FUNERAL 130 SPEER ROAD CHESTERTOWN, MARYLAND HOME, 21620 13 tellow 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ Manue disease or condition resulting in death) Hemostyn Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). law requires that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Box 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year detached 9 Unknown o within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? σ. Completed by 2 No 3 Probably 4 Unknown Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Serile Dementie or Attending Physician; The Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Eractioner: To the best of my knowledge, death oncurse at this time, date and blate, and due to the councils) and my the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) /11/illum, mo 12/30 D 21313 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rm 415 Washington Ave, Chestertown, MD KINK. WUN, MO

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

	Ų	1- For State Registrar	CML	Certifica	te of Dea	th			eg. No. 2011 4	
Physici. I Exami		1. Decedent's Name (First, Mid- Blake Michael		wa				Date of Dea Month November	nth Day Year r 22, 2011	3. Time of Death 1010 hrs
		4a. Facility Name (if not instituti	on, give street and nu	mber)			ocation of Death	S - 2	4c. County of D	eath
		Frederick Memorial F 5. Social Security Number		7 Age (la usa laat histh		lerick	T K Danian Odl Inc	In Data of B	Frederick	Pinter (O)
uneral irector		894–67–1591	6. Sex	7. Age (In yrs. last birthe	Mon	der 1 Year ths Days	If Under 24Hrs Hours Min	-	22, 2011	oreign
		Usual Residence of Decedent	IA W Z F		Yrs.			August	22, 2011	Country)Maryla
W any		10a. State 10b. County		10c. City, Town o						10d. Inside City Li
28a-f show d at once.	ctor	MD Frede	rick	Emmitsb		ip Code		T_1	log. Citizen of What (1 Yes 2 X
n or 28	Director	P.O. Box 371				217	27		USA	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status				dent of Hisp	anic Origin? (Sp Mexican, Puerto			merican Indian, Black,
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itural" amine	d by	15. Decedent's Education (Sp	or Dates:	de completed) 16a. De		I Occupatio	on (Give kind of v		Specify:	White ess/Industry
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giene. her th	Completed	0 17. Father's Name (First, Middle	a Last)	1	Inf	ant	3 Mother's Name	/Firet Middle	Infa Maiden Surname)	nt
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nd Mer is man	ဥ	19a. Informant's Name/Relation	ship (Type, Print)	19b.	Mailing Addres	s (Street	and Number or F	Rural Route Nur	mber, City or Town, S	itate, Zip Code)
ealth a	3	Elizabeth O. T	ramonte/M		O. Box Disposition (Na	371 E	mmitsbu	rg, MD	21727 20c. Location - Cit	v or Town. State
nt of H		1 Burial 2 X Cremation		om State cremator	y or other place	e)				•
portan		4 Donation 5 Other 5 21. Signature of Funeral Service	pecify: Licensee	National	Funera 22. Name an	1 Home d A <u>ddr</u> ess d	Crem 12,	/24/11	Falls Chu	urch, VA gton, VA 2
		Lawrence Klin	e perDVR							gton, VA 2
sician ledical		23a. Part I. Enter the disease, o failure. List only one cause	r complications that ca on each line.	aused the death. Do not	enter the mode	of dying, s	uch as cardiac o	r respiratory arr	est, shock, or heart	Approximate Int Between Onset
miner		Immediate Cause (Final disease or condition resulting in death)		consequence of):						Death
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and transit	Exar	events resulting in death) Last		consequence of):				-		
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is been signed by the attending physician should be detached for use as the burial	Physician/Medic	23b. Was decedent pregnant in t past 12 months?	I L LIVE D	irth 2 [ant at time of 5	Fetal death		Ectopic pregna	incy	Month	Day Year
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ned by detach	by P	Part II. Other significant condi		death but not resulting i	n the underlyin	g cause giv	en in Part I.		obacco use contribute s 2 ✓ No 3 ☐ I	e to the cause of death
sen sig		Diphenhydramine us	<u> </u>					24a. Was		e autopsy findings ava
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tificate or, page		25. Was case referred to medical	al I			26 Place o	f Death (Check	1 Yes	2 No 1 🗸	Yes 2 N
After this certificate has been uneral director, page 2 should	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 1	npatient 2 🗸 ER/Out	patient 3		ther:		Residence 6 0	ther:
After the funeral	ä	27. Manner of Death Natural 5	28a. Date FOUND	of Injury 28b. Tir Day,Year) FOUN	me of Injury	28c. Injury	!	28d. Describe child abuse	how injury occurred	
24 hours after death Funeral Director: stely filled in by the	Certification:	2 Accident Inve	stigation Nov 22,		nrs		s 2 V No	29f Logotion (Ctreat and Number of	r Rural Route Number,
ral Dir	ertif		id not be	Single Family Ho		y, omce bui		or Town, S		
within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the bes	t of my knowledge, death	occurred at th					
within 2 To the complet	Medical		and manner st	f examination and/or inv ated.				t the time, date		
₹ 🖺 🖇	2	29b. Signature and title of certifi		29	c. License			29d. Date signed		
3 F 8			11/12				_			2011
3 F 8		My Bus	who completed caus	e of death (Item 23a)		O.C.M	.E.		November 23	, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:40AM December, 18 ,2011 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Crisfield
If Under 1 Year If Under 24 Hrs. Nursing Somerset Tawes Home 8. Date of Birth (Month, Day, Year) March 7 1930 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 MM 2 □ F Maryland 218-24-4340 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Cristield Director Somerset Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21817 Somers Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Myes 2 No If Yes, Give Year or Dates: 1453-1955 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify. Black Specify: ģ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

1th grade College (1-4or 5+) Seafood abover. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Turpin Flossie Sterling ISAAC ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hwy, P.O. Box 49, Marion Station, MD Sarah Turpin -6450 Crisfield Neice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Veterans Cemetery 12/27/11 Hurlock, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fi cility Anthony E. Ward 30639 Princess Anne, MD, 2853 Hampden 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Disease of fight that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2/2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1XX Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1¥ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 48098

Registrar
DHMH 17 Rev 1/2001

State

park

alumbunathar

32. Registrar's Signature

201 Hall Highenay (notred MV 218)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEC 2 0 201

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** OCAM ec. 201 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Nauches er arvo 105 Wen If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrş. last birthday, Funeral Min. Months Days Hours 1 M M 2 □ F 215 05328 Director ela Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Examine must be notified at Manc 1 ☐ Yes 2 ☑ No Funeral Director avro 10f. Zip Code 10g, Citizen of What Country' 10e. Street and Number Wen items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 □ Divorced 'natural' Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tioneer Ith and Mental Hygier
7 is marked other the traumatic event, Its 18. Mother's Name (First, Middle, Maideg Surname, 17. Father's Name (First, Middle, Last) Be Wen ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauous. Son Maurice W. Wentz 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State 4 ☐ Donation # 5 ☐ Other (Specify) 21. Si nature of uneral Service Licensee anover Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus ____n each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the a should be detached f 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s 2 □ No 1 □Yes 1 ☐ Yes 2.2 No after death.

Lirector: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home Certification: To 1 Inpatient 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

filed (Month, Day,

Year)

DEC 27

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aegistrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar

1 - State Registrar

1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. Registrar I. Decedent's Name (First, Middle, Last) 2. Date of Death Wennich 3. Time of Death K. Leon Physician/ Month PM 18 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death The Johns Hopkins Baltimore last birthday) Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year Hours 167-14-2888 **Director** 87 1 🕅 M 2 🗆 F Apr 1, 1924 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified PA Lancaster Paradise 1 ☐ Yes 2 🌠 No 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country's ms 23a or Funeral 15 A Oak Hill Drive 17562 USA Page 1 and 2 should be filed within 72 hours after death "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Yes 2 No Yes, Give '43-'46 þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Clothing Elementary/Secondary (0-12) College (1-4 or 5+)
Unk the Owner/Manager Manufacturing of Health and Mental Hygier fitem 27 is marked other I r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stephen R. Wenrich Katie Harding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Loose Wenrich 15 A Oak Hill Drive, Paradise, PA 17562 (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date <u>o</u> <u>=</u> ₀ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) 12/22/2011 Schoeneck, PA Wellingers Luth. Cem 21. Signal (Fundal Service Course)
Martin D. Lawson MT1CHELL WIEDEFELD FUNERAL HOME, 6500 York Road, Baltimore, Mary HOME, INC. Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Gastrointestino Medical Due to (or as a consequence of) Examiner Sequentially list conditions CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown the be detached Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 TO NO Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifie HES-000 December 18 2011

DHMH 17 Rev 06-2011

State

Registrar

600 N. Wolfe St Baltimore Haryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

d

JAN 1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0550 M Wells velyn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REGIONAL MEDICAL NICOMICO 344156UN 1 Year If Under 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Unde Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 214-28-1583 Director 1 □ M 2 🕅 F 90 Jan. 19 1921 Maryland 28a-f show 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. once. 10c. City, Town or Location Director 1 X Yes 2 No Princess Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21853 U.S.A. 30671 Division permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceus.. Armed Forces?. Yes 2 No Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Black 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Private family Home Domestic 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ste warT Samuel M. (15 mma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , Orlando, Florida 32828 Wells - Daughter 12719 forestedge Circle (lementine 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 12-24-11 Rehobeth ☐ Donation 5 ☐ Other (Specify) M. E. Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony E. Ward MD, 21852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ່າ h sician/ Athero scleroinc Cardid Valcelar disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Secuentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the buri**a**l-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Dav 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending ours after death.

leral Director: Aff
filled in by the fu 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hour To the Funer completely file 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 068222 12/2/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Re State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-09825 State of Maryland / Department of Health and Mental Hygiene Douglas D. Young Certificate of Death 1- For State Rea. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Month Day December 30, 2011 Physician/ 1335 hrs **Medical Examiner** Douglas D. Young 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Charles Waldorf 9870 Moffitt Place 9. Birthplace (State or Foreign 8. Date of Birth(MM/DD/YYYY) If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number Country) **Funeral** Months Days Hours 6583 Georgia Oct. 4,1957 Director Yrs 1 XM 2 54 254 - 98 = 6Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County any Yes 2 XNo s 23a or 28a-f show notified at once. Waldorf t Pages 1 and 2 should be filed within 72 hours after death with the Maryland tment of Health and Mental Hygiene. Maryland Charles Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 20604-0023 P.O Box 23 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XNever Married 2 Married Black Specify: Yes 2 X No specify: If Yes, Give Year Divorced Widowed 4 16b. Kind of Business/Industry ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) it: If item 27 is marked other than other traumatic event, the M. dical 21215-0036 Senior Investigator FBI 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Barrett Be traumatic event, Warren J. Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 1803 Gordan Avenue Rome, Ga 30165 Bertha Barrett Young/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore. crematory or other place) 01/05/2012 1 X Burial 2 Cremation 3 Removal from State Canton, Georgia Donation 5 Other Specify: Georgia National Cemetery ä 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, MD 21215 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death Medical a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical \mathbf{x} AMENDED 5 per fh g923 1-31-12 vt UNPENDED physician the burial -23d Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death ed by the attending letached for use as 1 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 No 3 Probably 4 V Unknown signed b 2 ۵ Renal disease Completed 24b. Were autopsy findings available Division of Vital Records, 24a Was an has been s prior to completion of cause of autopsy performed? death? has ✓ Yes No 1 V Yes 2 page certificate 26. Place of Death (Check only one) After this certific funeral director, 1 Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be Residence 6 V Other: Scene Hospital: examiner? DOA Nursing Home 5 Inpatient 2 FR/Outpatient 3 1 🗸 Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 V Natural Yes 2 No Pending filled in by the fi 28f. Location (Street and Number or Rural Route Number, City Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 3 Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal within 2. and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 31, 2011 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Carol Allan, MD 32. Registrar's Signature 1. Date filed (Menting Par State Registra

ORIGINAL

OCME

DHMH 17 Rev 1/2001

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2/ 2024 M Kenneth Lee Younes Medical Prince George's 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** College Park 4815 NiagaraRoad Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 😾 M 2 🗆 F Months Hours Decth. 28, 41952 Ffortida 58 257-88-7572 Director Usual Residence of Decedent show 10d. Inside City Limits 1 Yes 2 No 10b. County 10a. State 10c. City, Town or Location notified at Director College Park Maryland Prince George's 28a-f 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code ō ed other than "natural", or items 23a o event, the Medical Examiner must be 20740 Funeral 4815 Niagara Road permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Race - Anie... Black, White, etc. White 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No 1X Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: If Yes. Give Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) U.S. Department of Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4-9r 5+) Elementary/Seconday (0-12) Chemist Agriculture Be 18. Mother's Name (First, Middle, Maiden Surname)
Norma Gose 17. Father's Name (First, Middle, Last) ၉ Ray Younes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1233 Laquita Drive Arab, Alabama 35016 William Cash -brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia 12/27/2011 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licensee Bohald VoresBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Atheroscherotk Heart Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-top. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 1 Yes 2 L 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Pes 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 10 2011

Registrar

State

31. Date filed (Month, Day, Year)

DEC 2820

3001

11-09408 Laria Nicole Allen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

tate	of	Maryland	/ Department	of Health	and	Mental	Hygiene

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		1- For State Registrar Certificate C	of Death	Reg. No.	011 4017
Physici Medical Exam		Decedent's Name (First, Middle,Last)		Date of Death Month Day Y	3. Time of Death 'ear 1015 hrs
MEUICAI EXAIII	mei	Laria Nicole Allen 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	December 14, 2011	ty of Death
		4423 Rena Road	Suitland		George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs, last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min		YY) 9. Birthplace (State or Foreign
Director		183-56-2465 1 M 2 xF 41 Y		Apr. 3,197	
áu a		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
. ₹	_	MD Prince George's 4423 Ren	na Road. Suitla	and. MD	1 Yes 2 No
Maryland 28a-f sho	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of V	What Country?
h the l 13a or 10tifie		TTES TIONA ROAG	20746		States
0036 within 72 hours after death with the Maryland jene. rer than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	Funeral	1 Never Married 2 X Married Armed Forces? If	/as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		ce - American Indian, Black, nite, etc.
fter de ", or		3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:	Specify	: Black
ours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	ent's Usual Occupation (Give kind of working life, DO NOT use reti		Business/Industry
5-0036 led within 72 hou Hygiene. other than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	,	, , , , , , , , , , , , , , , , , , ,	/ 5
5-00; ed with tygiene other t	E O	12 Hos	18.Mother's Name	(First, Middle, Maiden Surnam	mestic
21215-0036 ald be filed within 7 Mental Hygiene. marked other than	Be	Westley Johnson	Henriet	ta Allen	
ID 2/ Should and Me 17 is ma	2		ng Address (Street and Number or F		
≥ c que		20a. Method of Disposition 20b. Place of Dispo	C. Herman St.,		n - City or Town, State
Baltimore, permit. Pages I as Department of He Important: If ite		1 Name of the second state		/17/11 Cinn	amingon NT
Baltimor permit. Pages I Department of I Important: If injury or other		27. Signeture of Funeral Service Accessee 27. Signeture of Funeral Service Accessee 22.	Name and Address of Facility	es Euneral Se	rvice P
E F C E		Callyon C. Danjan 17	01 McCullah St.	salto Md.	21217
Physician // // // // // // // // // // // // //		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac o	r respiratory arrest, shock, or h	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of):			Death
		Sequentially list conditions, b. Cardiac Fibrosis			
	jne	if any, leading to immediate Due to (or as a consequence of):			
sit sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, icate be executed physician and the burial - transit		d. ☑ UNPENDED ☐ AMENDED 23a,b,27 per 1	me	•	
60, ate be shysicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	mc 6724 2 2 12 VC	23d. Date	of delivery
687 certific ading p		past 12 months?	etal death 3 Ectopic pregna	ncy Month	Day Year
Box 687 he death certific the attending pred for use as the	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 C	ther (Specify)		
ires that the signed by the detached		Part ii. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		ntribute to the cause of death?
S, P uires th n signe	ed by				3 Probably 4 ✔ Unknown
ord aw reg as bee 2 shou	Completed			24a. Was an 24b autopsy performed?	. Were autopsy findings available prior to completion of cause of death?
tal Reco	힝			1 ✓ Yes 2 No	1 Yes 2 No
ltal sician: is certi irector	B	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26.Place of Death (Check of 3 DOA Other,4 Nursin	only one) g Home 5 Residence 6	Other: Scene
n of Vital Recing Physician: The After this certificate funeral director, page	2	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of		28d. Describe how injury occu	
ion tendir tor A	atio	1 Natural 5 Pending 2 Accident Investigation	1 Yes 2 No		
Division of Vital Records, tal or Attending Physician: The law requirers after death. To be ector: After this certificate has been siled in by the finneral director, page 2 should be	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	et, factory, office building, etc.	28f. Location (Street and Num or Town, State)	nber or Rural Route Number, City
Cospita f hours		29a. Certifier	urrod at the time date and place and	due to the source(s) and mann	ar as stated
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H > F 8	Š	29b. Signature and title of certifier	29c. License number		gned (Month, Day, Year)
\.		Mu SMI)	O.C.M.E.	Decembe	er 15, 2011
V		30. Name and address of person who compléted cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900	W. Baltimore Street Baltim	ore. MD 21223	
St	ate		Janimore Otreet, Danim		
Regist	rar	31. Date filed (Month, Day Year) JAN 1 9 2012 32. Registrars Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:38p^M Gladys Beatrice Allen 12/14 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 213-58-2725 **Director** 1 🗆 M 2 🔀 F 93 02/11/1918 Trinidad Usual Residence of Deceder 28a-f shov 10b. County 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at 10a, State 10c. City. Town or Location Director 1 X Yes 2 No Washington, DC DC 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2900 14th St., NW Apt. 616 20009 Trinidad death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Examiner Armed Forces? ō ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates ^{Specify:}Black "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) seamstress textile 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ Gittens Simeon Baptiste 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethnie G. Allen (daughter) 2900 14th St NW #616 Washington, DC 20009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Glenwood 12/27/2011 Washington, DC 22. Name and Address of Facility WH Bacon Funeral Home 21. Signature of Funeral Service Licenses 3447 14th St NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phylician Septic Shock disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examir and Cause (Disease or injury that initiated events resulting in death) Last Possible Aspiration or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) nding physiciar buri Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No ξ Month Day Year Pregnant at time of death the P.O. ed by t detach been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has le 2 s certificate has director, page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 🗸 Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 20c. License number 12/15/2011 D0067279

State Registrar Forest Glen Rd

1500

2. Registrar's Signa

Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Veerappan Alagarsamy

DEC 27 2011

31. Date filed (Month, Day, Year)

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,1	Examir		4a. Facility Name (if not institution, gi		_				4c. County of De				
	Funeral	-	Southern Maryland 5. Social Security Number 6.	<u> </u>	al Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.								
	Director			1 □ M 2 X F	82 Yrs.	Months Days	Hours Min.	(Month, Da	(Month, Day, Year) Country)				
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	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number		10, 11	10f. Zip Code			10g. Citizen of What 0	Country?			
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98	fter de , or its amine	þ	1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, specify Cub	oan, Mexican, Puert		Black, Wh	ite, etc.			
8	ours a	eted	3 Widowed 4XX Divorced	If Yes, Give Year or Dates.		1 ☐ Yes ※ X No Specify: dent's Usual Occupation				Filipino			
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Σ,	nd 2 s ealth a m 27 i		Eloisa Dano / Da	ughter	7910	Carey I	Branch Dr	. Ft. Wa	shington.	MD 20744			
Baltimore,	Page 1 annent of Hant of Hant: If ite		20a. Method of Disposition 1 ☐ Burial ※※ Cremation 3	Removal from State		ematory or other pla	12/2	Date 24/2011	20c. Location - City of				
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m	permii Depar Impor any in		126. K	4	ϵ	160 Oxon	Hill Rd.	Orge P. Oxon Hi	Maryla 11, Maryla	eral Home PA and 20745			
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Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as the to the funeral for use as the the funeral director.	Physician/Medi	IF FEMALE:	23c. If yes, outcome o	f pregnancy					17			
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۵	To the Nospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director,	cal	29a. Certifier 1 Sertifying Ph	ysician: To the best of m	v knowledge death	occurred at the tim	ne date and place :	and due to the ca	use(s) and manner as	stated			
	he Ho iin 24 h he Fur ipletely	Medical	(Check 2 L Medical Exar	niner: On the basis of exa rse Practitioner: To the	amination and/or inve	stigation, in my opini	ion, death occurred a	at the time, date a	nd place, and due to the	e cause(s) and manner stated.			
			29b. Signature and title of certifier	Ligo		29c. Licens			29d. Date signed (Mon				
	ED		30. Name and address of person who	completed cause of de	ath (Item 22a) (Tuno	Drint)	52865		December 2				
	1		K. Michael File	ARD MY	(2150 Ann	apolis Re	and Ste	250 Gl	en Delo, M.	0 20769			
	Stat Registra	te ar	31. Date filed (M TEC, 2 7 20	32 Registrar	s Signatus.	and			en Dalo, M.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Item 28f per me, g923,01/25/2012dhb Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 1 1244 Eulalia C. Abeyta 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death 15660 Ensleigh Lane Boure 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs, last birthday) Days Hours Septh, Pag Year) 934 New Mexico 77 **Director** 525-68-2599 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Cheyenne WY Laramie 1 🗆 Yes 2 🗐 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 82007 U.S.A. 1309 Ahrens Avenue 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 1 Never Married 2 Married Black, White, etc. ģ 1 Yes ... If Yes, Give 2 **X**No Maryland 21215-0036 1 □XYes 2 □ No Specify: Mexican "natural", 3 Widowed 4 Divorced White Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rafael Trujillo Merenciana Romero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code S permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra 1309 Ahrens Avenue, Cheyeene, Wyoming, 82007 Jose Abeyta - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-24-2011 Baltimore, MD 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death (omplications Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any treating to immediate cause. Enter Underlying Diale to (or as a consequence of): Exami that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death signed by the a Id be detached f Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed las been siç 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performed 2 🗌 No ☐ Yes 25. Was case referred to medical examiner2 Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Sp.Son's Home 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending Lone within 24 hours after death.

To the Funeral Director: All completed filled in by the fu CENKNOWM Accident Investigation 1 Tes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1309 Ahrens Ave. Cheyenne, Wyoming determined building, etc. (Specify) home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/ar inventional control of the control of the cause (s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 1405 State Registrar

Amend #20B po		1 10000			k Indelible I			•	_	gible.		
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Funeral Director		5. Social Security Number 341-12-9938 1 Usual Residence of Decedent	x	91 yrs. last birtho	Months Day		Min.	Date of Birth (Month, Day, 9/11/1	Year)	Co	thplace (State or untry) inois	Foreign
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farylai should be and Menta is marked		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. l	Mailing Address (Stre	-				State. Zir	Code)	
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Baltimore, N permit. Page 1 and 2 Department of Healt Important: If item 22 any injury or other u		20a. Method of Disposition 1 XBurial 2 Cremation 3	Damaval from State		isposition (Name of crematory or other p	lace)	Date	unk	20c. Location	- City or	Town, State	
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		30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Typ	pe, Print)	500		1 - 1	rate	> 0	Colon	7-Dr
a/		31. Date filed (Month, Day, Year)	+2000		Di	1.te	1-	A	Annay	العد	5 77)2	4407
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 25 AM DEV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Umper Har esapeake Moshita Social Security Number If Unde 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 6. Sex 1 Year Director 213-40-1205 1 X M 2 □ F 72 Nov.26,1939 Maryland Usual Residence of Decede show at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Port Deposit Maryland 1 Yes 2 XNo Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21904 U.S.A. 7 Blue Bell Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 🖾 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
V.A. Medical Center (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Perry Point, Maryland Environmental Management Eleven Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental I Joseph Edward Akins Gertrude Akins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trauronce. Helen B. Akins (wife) 21904 Blue Bell Court, Port Deposit, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 😾 Burial 2 □ Cremation 3 □ Removal from State Berkley Cemetery 01/06/12 4 ☐ Donation 5 ☐ Other (Specify) Darlington, Maryland . Signa ure of Funeral Service License ^{22. Name} and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21903-0766 Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner recad Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law has autopsy performed this certificate 1 Yes 2 No 1 🗌 Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Yes 2 N No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 o 27. Manner of ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred tural 5 Pending work Division 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours a To the Funeral L Medical Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Gertifying Nurse Frantitioner: To the best of my knowle 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sapealle Month, Day, Year) 31. Date filed (Month. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Time of Death :39 Physician/ marews AM Medical 4c. County of Death 4a. Facility Name Town, or Location of Death (if not institution, give street and nur **Examiner** Hmore N/A Ade (In vrs. last birthday) 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Data of Birth **Funeral** Months 110-72-8081 **Director** 1 □ M 2 🕅 F 42 Jun. 17, 1969 Guyana Usual Residence of Dec 28a-f show 10d. Inside City Limits at 10a. State 10c. City, Town or Location Director traumatic event, the Medical Examiner must be notified XX Yes 2 No MD Prince George's Bowie or. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a U.S.A. 20715 13100 Silver Maple Court items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces⁴ Black, White, etc. 10 by 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☐ No If Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Private Schools Teacher Be Page 1 and 2 should be filed vent of Health and Mental Hyy ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Josephine Patterson Joseph Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 13100 Silver Maple Court, Bowie, Maryland 20715 Martin L. Andrews/Husband injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Burial 2 Cremation 3 Removal from State MD veterans cemetery 1-10-2012 Crownsville, MD Donation 5 Other (Specify) @ Crownsville permit. 22. Name and Address of Facility Beall Funeral Home Funera Service Licenses 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) o (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be Box 68760 as the l IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ate has been signed by the atterpage 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Vinknown P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; I 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 2 X No ၉ No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natura 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 20

Registrar

State

gistrar's Signature

"Wolfe Street Baltimore, MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Reg. No.

Certificate of Death

Reg. No. 1 - For State Registrar Reg. No. Z 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2 o// Month Physician Richard Andrews 7:05 PM 10 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Western Maryland Hospital Center Washington Hagerstown 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min 1 XM 2 ☐ F 220-40-6474 Yrs. 69 Director Oct. 2, 1941 Washington DC Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 3a or 28a-f show t be notified at 1 Yes 2 No Director Maryland | Prince George's Beltsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4412 Island Place Unit 202 20705 U.S.A. "natural", or Items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 TYPes 2 No Air If Yes, Give Year or Dates: Force 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Computer Programer Computers permit. Pages I and 2 should be filed with Department of Health and Mental Hyglene Important: If Item 27 Is marked other that any Injury or other traumatic event, the angles. 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Andrews Elenore Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Friend) William Flank 20421 Bunker Hill Way Ashburn, Virginia 20147 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 20, 1 ☐ Burial 2 Marcremation 3 ☐ Removal from State Smithsburg, Maryland Smithsburg Crematory 4 □ Donation 5 □ Other (Specify) 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home M01414 John 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. t and Immediate Cause (Final Physician Gastrointestinal Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner ROVED BY MEDICAL EXAMINER he law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>ک</u> Anticoagulant Therapy; Chronic Alcoholism; Pulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Embolism; Diabetes Mellitus; Chronic Obstructive Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 autopsy de Pulmonary Disease; Atrial Fibrillation 1□ Yes 2 NO To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this c Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 1 1 10 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) 0/1 1500 Pennsylvania Avenue Hagerstown, MD 21742 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 3 2012 Registrar

DHMH 17 Rev 1/2001

Indrews, Kiehary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ Allen 0137 ZODNE 2611 Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett County DAKEAND Memorial Hosp sarvet If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months Hours Min. 04/1 9y/ Country) 235-21-3284 **Director** Usual Residence of Decedent 10a. State 10b. County 10d, Inside City Limits filed within 72 hours after death with the Maryland items 23a or 28a-f shorer must be notified at 10c. City, Town or Location Director 1 ¥ Yes 2 □ No WV Tucker Davis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 433 Fifth Street 26260 Was Deceus.
Armed Forces?
Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status an "natural", or iter Medical Examiner Black White etc. þ 1 Never Married 2 Married 1 Yes 2X If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: Completed 3 Wildowed 4 Divorced 16b. Kind of Business Industry Blackwater Falls 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Madone. r than " life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) State Park Maintainence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Louise McCloud Ray Laten Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POBox 453 Davis, Ray L. Ball WV 26260 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12/28/2011 4 ☐ Donation 5 ☐ Other (Specify) Davis Cemeterv Davis. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hinkle Funeral Home, Inc. South WVPOBox 186 Davis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final Ph_sician/ ARTERIO SCUBROTIL CORONAR, VARCULA. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Date to Dinear elegandactiones of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): this certificate has been signed by the attending physician ral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗆 No Other: ၉ ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 Natural 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After (Month, Day, Year) 5 Pending injury 1 Pyes 2 No Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pau

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 27 Physician/ Jodie Lee Barger 148 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington County Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Jan. 22, 1956 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 🗆 M 2 🗓 F 213-68-5863 Mary Land 55 Director Jsual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director ms 23a or 28a-f s must be notified Maryland Washington County Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1129 Security Rd. 21742 U.S.A. ıral", or items ? I Examiner mus Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White "natural", 3 Widowed 4 Divorced Specify: Year or Dates if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Rep. Stationary Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Russell Lee Wetzel Vivian L. Eyler Wetzel 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd C. Evans-son 3 West Hanover St. Gettysburg, PA 17325 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oti 1

Burial 2

Cremation 3

Removal from State Smithsburg Crematory 12-30-2011 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Aspiration Prevmonia Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Chronic Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be \mathcal{O} Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? s after death.

Director: After this certificate Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 1 Tes 2 🗌 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work' 1 Yes 2 \square No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060396 17/78/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUR 5HED 21740 31. Date filed (Month, Day, Yea State DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:45p M Herbert Hershal Brown December 2071 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6403 Whittier Court Montgomery Bethesda If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X** M 2 □ F Days Country) Michigan March 28 367-42-5853 Director 70 Usual Residence of Decedent or 28a-f show e notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 6403 Whittier Court 20817 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: 27 is marked other than "natural", traumatic event, the Medical Exar Completed 3 Widowed 4 Divorced Specify. Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Law Firm 5+ Lawuer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٥ David Brown Marion Ginsburg 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Andrea Leader Brown - Spouse 6403 Whittier Court, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ☐ Donation 5 ☐ Other (Specify) Judean Memorial Grdns 12/26/2011 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 21. Signature of Funeral Service Licensee M-1564 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Myeloid Leukemia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 凝 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law autopsy performed? Yes 2 X No certificate 2 No 1 Yes of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 👿 Residence 6 🗆 Other (Specify) 1 Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 \square Pending injury work? Division within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year, Lougithou, ms loce lyne D 63748 December 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou. M.D., 201 East University Parkway, Baltimore, Maryland 21218 31. Date filed (Month, Day, Year) State 27

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ HYMAN ELLIOTT BERNSTEIN 0219 PM DEC 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Columbia Howard County General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral Director** 078-18-2080 3-10-1924 1 🛛 M 2 🗆 F 87 New York Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 ☐ No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6336 Cedar Lane 21044 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates. WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Jewelry Supply Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, and Mental Fisherships is marked of ည Harry Bernstein Anna Rose Silverstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Item 27 i Beth Barkley - Daughter 13460 Sorghum Ct., Highland, Maryland 20777 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1. Department of I 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem Garden 12-28-11 Falls Church, Virginia Signature of Funeral Service Licenses 22. Name and Address of Facility Danzansky-Goldberg MO(597 Migheenhut 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ CLOSTRIDIUM DIFFICILE COLITIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner RENAL FAILURE ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury HYPERTENUSION that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box Live Birth 2 L Fetal deat
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day 1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 2 🗆 No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral vineral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Hospital or Attending injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number odoy. B. Navourt DEC 25,2011 D0051119

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

32 Registrar's Signature

10. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 CEDAR LANE, COLUMBIA, MD 21044 HOWARD COUNTY GENERAL MOSPITAL 5755 CEDAR LANE, COLUMBIA, MD 21044 UDAY B NAMANDAY, INTENSIVIST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jeanetta Berry December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Prince George's Examiner 4b. City, Town, or Location of Death aurel Regional Hospital Laure Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🏲 F Days Hours May 22, Year) 925 Dares, Maryland 579-30-7194 **Director** 86 Yrs Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: I fire 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 Ty Yes 2 No Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1077 Largo Road 20774 United States 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc. þ 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANo Specify. 3 Divorced Specify: Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 3 years Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Zellers W. Berry Edith V. Freeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred L. Richmond - Sister 5077 8th Street, NE Washington, DC 20017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Harmony Mem Park Jan 5, 2012 Landover, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Licensee wa 4001 Benning Road, NE Washington, DC 20019 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Metastatic Ph_sician/ Colon disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician To Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 yes, outcome of pregnancy
Live Birth 2 Live Betal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 Yes 2 No 3 Probably 4 Unknown Insulin Dependent Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Dyslipidemia 1 Tes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 KER/Outpatient 3 IDOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work? 5 Pending injury 2 🗌 No I Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 29, 2011 D53411 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #210 Bowie, MD 20715 Shesadri, MD 14300 Gallant Fox Lane, Date filed (Month, Day, Year) State JAN 0 4 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 4:50a M Jean Helena Baratelli December Medical 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** Frederick Homewood at Crumland Farms Frederick If Under If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 8. Date of Birth Social Security Number Funeral Hours (Month, Day, Year) **Director** 365-32-8277 1 M 2 X F 79 March 19, Michigan Usual Residence of Deceden 28a-f show the Maryland at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No Frederick Maryland Frederick or 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? pe 23a Funeral must | United States 7407 Willow Road 21702 items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Examiner Black, White, etc. 9 ò 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 X Divorced White Completed Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Flementary/Secondary (0-12) College (1-4 or 5+) Hygiene. the Medical Assistant Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o 2 Robert Theodore Ross Aileen McAdoo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 841 Hanley Avenue, Los Angeles, California 90049 Joseph Baratelli/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Stauffer Crematory Inc 12/22/11 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland. 21. Signature f F ral Service Lives 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes Pike, P. A. Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or Onset and Death Immediate Cause (Final Physician/ relimanca disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Gause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): as the burialattending physiciar Physician/Medical that the death certificate be Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months
1 Yes 2 No for Dav Pregnant at time of death the Unknown by 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has page 2 1 ☐ Yes 2 ☐ No de Yes 2 Division of Vital or Attending Physician: 25. Was case refer 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4- Nursing Home 5 Residence 6 Other (Specify) 27. Manner o ath 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After the in by the funera 28c. Injury at 28d. Describe how injury occurred Certificate: iniury Tatural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after
To the Funeral Direc
completely filled in b after To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c License number 23a) (Type, Print) ed cause of death (Item

State Registrar 31. Date filed (Month, Day, Year,

aistrar's Sianature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Russell Glenn Bradley December 18 2011 7:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Walkersville Glade Valley Rehabilitation Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 **№** M 2 🗆 F 85 Months Days March 13, Year 926 Oklahoma **Director** 447-12-9051 Usual Residence of Decedent 28a-f shov with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🔀 No Maryland Frederick Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20841 United States 23520 Shiloh Church Road Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1
Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or i any injury or other traumatic event, the Medical Examin once. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed WWII 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Nuclear Physicist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lula Gertrude Roller ၉ Russell Otho Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3990 Farm Lane, Monrovia, MD 21770 Kitty Bradley / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec.Date1, 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State Frederick, Maryland Resthaven Crematory 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur - uner Service Licensee Skkot Cody P.A. Frederick, MD 21701 Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. 23a. Part 1 Inter the pisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ailure. List only one cause on each line. Month Death Immediate Cause Final disease or condition resulting in death) Physician/ Dysphagea Syndrome Medical Due to (or as a consequence of) Examiner 6 Months Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify, 2 X No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) December 21, 2011 D26516

Registrar
DHMH 17 Rev 7/2009

(x)

State

Allen J. Cils
31. Date filed (Month, Day, Year)

1475 Taney Avenue, Frederick, MD 21702

arks

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Cilson, M.D.

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Physician/ 09: 15 AM BURDICK 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** HOSPITAL MIONTGOMERY GENERA MONTGOMERY OLNEY 6. Sex , 1 M 2 K F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min. 01/08/1918 Director PA 578-18-2969 Usual Residence of Decedent show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MONTGOMERY DICKERSON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 20842 21420 PEACH TREE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC HOUSEWIFE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JOSEPHINE NARDIELLO JOHN DANIEL SCOPI, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21418 PEACH TREE RD., DICKERSON, MD 20842 GREG BURDICK / SON Baltimore, 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of H Important; If ite any injury or ot 12/31/201 | SILVER SPRING, MD GATE OF HEAVEN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fanaral Service Licen 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, $\forall \mathcal{N}$ MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Death Immediate Cause (Final Physician/ RENAL FAILURG ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** hours HYPERKALEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine as the burial-transit METABOLIC ACIDOSIS Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical HYPERNATREMIA Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 🗌 No 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🔀 No ٩ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of e Hospital or Attending P 124 hours after death. e Funeral Director: After t 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) e Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and tible of certific 29d. Date signed (Month, Day, Year) 2011 D72505 HOSPITALIST of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 3 BRIDGIT ALUNKARA 20832 18101 PRINCE PHILIP DR., OLNEY, egistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30, 2011 1846 P M December Andrew W. Barnhart Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Montgomery Olney Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Davs Hours (Month, Day, Year) Country) **Director** 176-36-9823 1940 71 30, New Jersey Usual Residence of Deced shov with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗌 Yes 2 🛢 No Maryland Gaithersburg Montgomery 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 20882 United States 25012 Woodfield School Road death 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ral", or iter Examiner Black, White, etc þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or ☐ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. item 27 is marked other than ' other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 6 Scientist Consulting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frederick C. Barnhart Evelyn Toupee Barnhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joanne M. Barnhart, Wife 25012 Woodfield School Road, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place)
All Souls
Cemetery 1 🖫 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan.6,2012 Germantown, Maryland 22. Name and Address of Facility Molesworth-Williams, P.A., Funeral Home Signature of Faneral Service Licen 26401 Ridge Road, Damascus, 23a. Part 1 Enter the disease e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death Ph. sician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Hospital or Attending Physician: The law requires that the death of 24 hours after death.
 Funeral Director: After this certificate has been signed by the atter been signed by the atte should be detached for in the past 12 months? Year Pregnant at time of death Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 0050410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BRYANT JEROME BODDY SR DECEMBER 30. 2011 9:50 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 48 EAST BELAIR AVENUE. 3 APTABERDEEN HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country)
MARYLAND Months Days 1 🕅 M 2 🗆 F JUNE 16, Year) Hours Min. Director 217-62-3875 56 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND HARFORD ABERDEEN 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral 48 EAST BELAIR AVENUE, APT 3 21001 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ۵ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 CUSTODIAN NURSING HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PRESTON VERNON BODDY SR LILLIE ELIZA REED 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21911 SHAUNTE BODDY (DAUGHTER) 37 LILLIAN CIRCLE, P.O. BOX 1035, RISING SUN, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o
once. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 1/9/12 GLEN BURNIE, MD 21. Signature of Funeral Service Licenses Name and Address of Facility LISA SCOTT FUNERAL HOME, 552 LEWIS STREET, HAVRE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on e Interval Retween Onset and Death Immediate Cause (Final Gliublas Priysician disease or condition resulting in death) **Medical** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to or as a consequence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: IF FEMALE: 23b. Was deceden prognant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy After this certificate Yes 2 the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **N**O ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death. 1 Yes 2 🗆 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 4 Homicide within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Dav. Year) Maryland 22 S. Everne St Bultimore State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month DECEMBER 38, 2011 Physician/ 2137 PM reeMan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Easton Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min. (Month, Day, 11-27-Director 1 1 M 2 □ F Mary land items 23a or 28a-f show 10c. City, Town or Location Examiner must be notified at Director bridge 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21613 5 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Black Completed 3 Widowed 4 Provinced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygien Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ SSa reeman Tazwell 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Department of Health ar Important: If item 27 is any injury or other trau Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Shore Grenation ambrid 4 Donation 5 Other (Specify) 1 d 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, Funeral 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ jang ene disease or condition resulting in death) Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and -tran Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be tereamia Box 68760 attending physical for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) the P.0. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe Yes 2 ANO certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗷 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1
Yes 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After ompletely filled in by the funer injury 5 Pending A Natural 2 🗌 No Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 31 0308 2011 Earl P. Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 930 December Court Gambrills Anne Arundel 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month, Day, Year) 578-44-6946 Director 1 XM 2 - F Washington DC Yrs Nov. 26, 1934 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 Yes 2 No MD Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 930 December Court 21054 U.S.A death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Black, White, etc. 1 Never Married 2 X Married ò 1 Yes 2 No
If Yes, Give
Year or Dates. by altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Licensed Investigator ABC Board 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည Anna Sharkev George H. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau once. Joan T. Brown/Spouse 930 December Court, Gambrills, MD 21054 20b. Place of Disposition (Name of cametery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 🔣 Burial 2 🗌 Cremation 3 🗌 Removal from State incoln Cemetery | 1/6/2012 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) Pregnant at time of death bed 1 s been signed by th 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 : has 1 Yes 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifical completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tyes 2 No 4 Nursing Home ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1. Natural 5 \square Pending Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practition at To the best of my incordaction of the form of the first in the cause of the ca 29b. Signature and title of certifie 20 6 moleted cause of death (Item 23a) (Ty ENSE HWY

Registrar
DHMH 17 Rev 06-2011

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 25 Per me, g923,01/12/2012dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Michael Physician/ December 9 Biddle 483 8 701 Medical Facility Name (if not institution **Examiner** Baltimore inty of Death Istown If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** Director MD 10a. State 10d. Inside City Limits the Maryland Completed by Funeral Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified 1 Yes 2 No 10g. Citizen of What Country? 21133 Henwood Ad. and 2 should be filed within 72 hours after death with 1.SA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) ath econdary (0-12) College (1-4 or 5+) and Mental Hygie is marked other Be Father's Name (First Name (First, Middle, Maiden Surname)

Smith ၉ pr Town, State, Zip Code) Randallstown, MD 21133 Department of Health ar Important: If item 27 is any injury or other trau Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signat 70 Fredhilkn Kass Belta mo 2122 or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Approximate Interval Between shock Immediate Jause (Final Onset and Death Physician/ Pneumonia disease or condition resulting in death) Medical , Examiner s conseq ence of): Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as the burial-transit ANUXIC encepho and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 CERTIFIC as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No Day Pregnant at time of death be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: Interaw within 24 hours after death.

To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2: autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 6 Tother specify hospice Hospital Other: 1 X Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title D0053337 December 10 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Are Ste 203 Seam Baltmore, Md 21209

State Registrar Dow

31. Date filed (Month, Day, Year)

JAN 1 3 2012

2835

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amend 8.13 per inf , 923 1-23-12 sm Please Type or Print in Black Indelible link. Ensure All Copies Are Legible.

	Sta	te	30. Name and address of person who completed cause of death (Iter HASAN AWAN 2717 HA 31. Date filed (Month, Day, Year) 12. Registrar's Signy 13. Date filed (Month)		~ ~ ~ ~ ~ ~	FRYRI) BAI	TINO	RE, A	aD 21227	
	To t To t Con	2	29b. Signature and title of certifler		29c. License				ber 31	, Day, Year) , 2011	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my known one of the pass of examiner: On the basis of examiner and manner stated.		nvestigation, in my op	pinion, death occu		date and pla	ice, and due	to the cause(s)	
Divis	ital or Attencurs after deathral Director:		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Speci	ty)			City or To	vn, State)		ral Route Number,	
Division of Vital Records,	nding Physic ath. r: After this or e funeral dire	Certification: To f	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	ER/Outpatie 28b. Time o Injury	of 28c. Injury Work	4.23 Nursing H	ome 5 Resi 28d. Describe			ify)	
ital B	Physician: The le	Be Con	25. Was case referred to medical examiner?			26. Place of Dea	1 □ Yes		death? 1 ☐ Yes	2 No	
ecorc	law requir as been s 2 should	Completed	DEMONIA				24a. Was	an 2	4b. Were aut	bably 4 \(\overline{A} \) Unknown opsy findings available ompletion of cause of	
ls, P.O.	res that th signed by be detacl	by	Part II. Other significant conditions contributing to death but not res	ulting in the u	underlying cause give	n in Part I.				the cause of death?	
O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. To the Funeral Directour: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	/sician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown 23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of 0 9 □ Unknown	aldeath 3	□ Ectopic pregnancy			23d.	Date of delive	very Day Year
68760,	rtificate be executed og physician and as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Unidentified Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequenc								
	Examiner	e.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the consequence o							Li veri	
	Physician √Medical	3. 11	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Interval Between Onset and Death				
Ba	permi Depar Impo any Ir	0	21. Signature Funeral Supre Licent de Directo 23a, Part . Enter the disease, or complications that caused the deat	B	tate Anato altimore,	omy Board MD 2120)1		imore	Approximate	
altimore,	it. Pages urtment of ortant: If its njury or o		4 □ Donation 5 ■ Other (Specify) in state		osition (Name of matory or other place 2. Name and Addres)					
e, Ma	s 1 and 2 s of Health ar item 27 is other trau		Antonio Asa/son	3113	Clifton A	Avenue B		, MD	21216 on - City or To		
Maryland	hould be nd Menta marked matic ev	To B	Joseph Carey Taylor 19a. Informant's Name/Relationship (Type. Print)	19b Maili	ng Address (Street a	Minnie .					
d 21	filed wit I Hygien other the ent, the	Be Con	17. Father's Name (First, Middle, Last)	hon	memaker	18. Mother's Nam	e (First, Middle,		home		
21215-0036	hin 72 he e. an "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	edent's Usual Occupa e kind of work done di DO NOT use retired)	tion uring most of work	ing	16b. Kind o	f Business/In	dustry	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is invoiced. From the results inclined at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ↑ Yes 2 No.	Specify: Pano			Black, White, ecify: b1a	etc.	
	s 23a or	Funeral Director	606 N. Ashburton Street	2 42	21	216	if- Was an Na		ISA Race - Americ	eon Indian	
	the Mar 28a-f sh	rector	MD 10e, Street and Number	Balti	more			10g. Citizen	of What Cour	1X1Yes 2 □ No	
	yland			ty, Town or Lo					1	0d. Inside City Limits	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs.</i> 1		Months Days	Hours Min.	8. Date of Birt Februth, Da 13	h y, Year) 1924	Coui	place (State or Foreign ntry) y Land	
	Examin		4a. Facility Name (If not institution, give street and number) FUTURE CARE-ITUINATION 22 S AH	nol Ave.	4b. City, Town, or I BAI+im			4c. Cou	nty of Death		
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) MARIE BLACKWELL				2. Date of Dea Month DECEMB	Day	Year 2011	3. Time of Death 5'05'4 M	
		·	State of Marylan State Amend Item 29d per dr.,g9	23,017 Ce	19/2012dh rtificate of D	eath			0	43192	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16:10 PM Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Deat 4c. County of Death **Examiner** Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Dec. 20, 1938 467-60-5061 Hours South Carolina **Director** 1 🔀 M 2 🗆 F 73 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at 10b. County Director 1 X Yes 2 □ No Maryland Baltimore 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 116 South Broadway 21231 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc "natural", or þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Robert Brown Blackmon Nettie Benfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12113 Maddox Lane, Bowie, Maryland Marvin Blackmon, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ArdentCremation, Inc. 1-7-12 4 Donation 5 Other (Specify) Hanover, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death 515 Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due o (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Yes Unknown g Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2 No 1 Yes funeral director, 25. Was case referred o medical Be 26. Place of Death (Check only one) examiner? Hospital 2 V No Other: 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred √ Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifie of person who completed cause of death (Item 23a) (Type, Print) 11 Tarla 32. Registrar's Signatur arka State

Registrar

			State of Maryland / Dep			
		4	1 _ State	artificate of Death		2011 1.3 191
		·	Registrar 1. Decedent's Name (First, Middle, Last)	tillcate of Death	2. Date of Death	3. Time of Death
	Physicia		Dorothy Ellen Coddingt	on	Dec. 24	Dav Year
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Door D	4c. County of Death
1	Examin		Allegany Nursing & Rehab.	Cumberland		Allegany
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign country)
	Director		215-20-6991 1 M 2 M F 89 Yrs. Usual Residence of Decedent		11/27/1	922 Maryland
	nd show at	I. I	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	fanyla Ba-fs tified	Director	MD Allegany Cumber	Land		1 Yes 2 □ No
	the h		10e. Street and Number	10f. Zip Code	100	. Citizen of What Country?
	nust I	Funeral	107 Furnace Street	21502		U.S.A.
	deatl		Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	after al", o	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No 3 🖫 Widowed 4 ☐ Divorced Year or Dates.	1 ☐ Yes 2 🔀 No Specify:		Specify: White
9	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	. 16	b. Kind of Business Industry
215	in 72 e. han "r	ള	(Specify only highest grade completed) (Give	kind of work done during most of work OO NOT use retired)	ing	
7	within ygiene.	l as		Homemaker		Home
and	e filed ntal Hy ed oth event	To B	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	den Surname) Howe
ž	should be file and Mental I ris marked or raumatic eve		Lewis Beckman 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	n Elsie ing Address (Street and Number or Run	al Pouta Number Ci	
Maryland 21215-0036	O = 2 =			Paull St., Oakl		·
ē,	1 and 1 and 1 item 2 other		20a. Method of Disposition 20b. Place of Disp			c. Location - City or Town, State
m	Page nent c ant: If ury or			d Cemetery 12/	28/11	Dakland, Maryland
Baltimore,	permit. Page 1.8 Department of P Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Ne	wman FUr	neral Homes P.A. kland, MD 21550
			23a. Part 1. Enter the disease, or complications that gaused the death. Do not en			Approximate
	Priysician/	22 /4	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition at the condition at t	12115111505	DEME	Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	Lefterices	DE NIC	MITATORETA
	Examiner	L	Sequentially list conditions, b.			
	р ‡	Examine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying			
	oe executed ician and ourial-transit	xan	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of):			
_	be exe	ज्ञ	L.			
)9/	icate g physis the	Jedj.				
89	certif anding use a	N/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery
Box 68760	death	Physician/Medic	in the past 12 mopris? 1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
P.O.	at the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e Did toha	cco use contribute to the cause of death?
Ч,	es that signed	Completed by	Takin Calo og inican contant of the calo	, , ,	1 ☐ Yes	2 No 3 Probably 4 Unknown
of Vital Records,	requi been shoul	lete			24a. Was an	24b. Were autopsy findings available
ec	e has	dwo			autopsy performe	prior to completion of cause of death?
E H	an; Th tificat tor, pa	BeC	25. Was case referred to medical	26. Place of Death (Chec		2 10 13 2 2 110
Ziti	nysici lis cer direc	P	examiner? 1	ent 3 DOA Other: 4 Nursing H	ome 5 Residen	ce 6 Other (Specify)
of	fter th		27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year) injury	work?	28d. Describe how	injury occurred
ion	tendi death tor: A the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	39f Logation /Stro	et and Number or Rural Route Number,
Division	al or A		4 Homicide determined building, etc. (Specify)	reet, factory, office	City or Town,	
	To the Hospital or Attending Physician: The law requires that the death certificate L within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the teaming the completed filled in by the funeral director, page 2 should be detached for use as the teaming the completed filled in by the funeral director, page 2 should be detached for use as the teaming the completed filled in by the funeral director.	Medical	29a. Certifier (Check (Check only one) . 3 Certifying Physician: To the best of my knowledge, death conly one) . 3 Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred	at the time, date and	place, and due to the cause(s) and manner stated.
	To the within To the Compl	Σ	only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
			1 Robustions / Bane A.	V-1486	5 '	VEC, 265 2011
	,	5	30. Name and address of person who completed cause of death (Item 23a) Type.			
		5	24 D 1 Cl 1 44- 44 D-1 Ve-al		201 Cur	mberland MD 21502
	Sta Registr		JAN - 3 2012 4. Hegistrar's Signature J. Jan	Ked		
	-		anii danii			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Physician/ Diane Beverly. Cronin December 2011 :55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House-Montgomery Hospice If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Months Hours Min (Month, Day, Year) Days Director 213-66-3559 1 M 2 X F 58 1953 Pennsylvania 2, Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at rector 1 X Yes 2 No Gaithersburg Maryland Montgomery ā 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a with 25 Bay Shore Court 20878 United States "natural", or items death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Veterinary Hospital Manager other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Pau1 Rabin Sherman Sonva 1 and 2 should be Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan L. Main/Spouse 25 Bay Shore Court, Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/24/2011 | Alexandria, Virginia Metropolitan Crem. 22. Name and Address of Facility DeVol Funeral Home ture of Funeral Service Licenses 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Ovarian Cancer Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): altrapsit The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): physician the buria Physician/Medical Box 68760 as t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Day Year 5 Other (specify) Pregnant at time of death Unknown g 🗌 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 😾 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes 2 X No ithin 24 hours after used...
o the Funeral Director: After this committeely filled in by the funeral dir ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 💢 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 06-2011

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State

29b. Signatura and title

Debrah Miller,

DEC 27

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

CRNP.

29c. License number

6001 Muncaster Mill Road, Rockville, Maryland 20855

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Pex FH 6924 2/01/2012 TH Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec. 21, 2011 Physician/ 1:25p M Claxton Janie Lee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 2010 Ray Leonard Road Landover Social Security Numb**329** 214–38–3328 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Davs Months Hours 192571936 York, s.c. 1 □ M 2 🏲 F 75 Director 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Prince George' MD Landover 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 USA 2010 Ray Leonard Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Black 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Bank Manager Be 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last)
Roosevelt Sanders 2 should be file h and Mental H 7 is marked ot permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 19a. Informant's Name/Relationship (Type, Print)
Calvin Claxton/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2010 Ray Leonard Road Landover, Md. 20785 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date St compten common of the class Methodist Ch.Cem 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/30/2014 York, South Carolina 4 Donation 5 Other (Specify) PHITE IP DO REMALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Onsetand Beath Atherosclerotic Cardiovascular Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a part of the cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Exami attending physician and for use as the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the atter in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death signed by the at Id be detached for 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed page 2 1 Yes 2 No 1 ☐ Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) 1 Tes 2 XNo 1 🗌 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 1 🔀 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D19731 Dec.21,2011 completed cause of death (Item 23a) (Type, Print) ing son 16#12 FT. hghMD 20ph State Registrar

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68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, out	tcome of pregr	nancy	7					23d. Date	e of deliv	ery	
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certificate:	(Check 2	Medical E	Physician: To the b caminer: On the bas Nurse Practitione	sis of examinati	ion and/or inves	tigation, in my opini	on, death occu	urred at the	e time, date a	and place	e, and due	to the ca	use(s) and m	anner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Franklin Delano Cliser 12:25 p M 2011 26. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Montgomery Hospice-Casey House 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Months Days Hours 579-42-6457 **Director** 1 🕅 M 2 🗆 F June 13, 1934 VA Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ,s 23a o, , must b Funeral 1924 Bonifant Road 20906 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No 14. Race - American Indian, Black, White, etc. 11. Marital Status r than "natural", or iter the Medical Examiner 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 SpecifWhite 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H should be Oliver Jett Cliser Elizabeth Jewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Matthews/Wife 1924 Bonifant Road, Silver Spring, MD 20906 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. 31 2011 1 K Burial 2 Cremation 3 Removal from State mportant: If injury 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, MD Signature of Juneral Service 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Tehend 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Gastrointestinal Stromal Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): g physician and as the burial transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as IF FEMALE: attending 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate Yes 2 X N 1 🗌 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence Hospice Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) R120698 Dec. 26, 2011 Micela Christerian CKNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Nicole Christenson, CRNP

DEC 2 9 2011

31. Date filed (Month, Day, Year)

32. Registrar's Signature

1355 Piccard Drive, Rockville, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 605 AM Cunningham Frances Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Union Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 11, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min Year) 1945 66 124-64-3195 **Director** Oct North Carolina Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State Director 1X Yes 2 □ No Clinton Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be r Funeral 20735 United States 6918 Northgate Parkway 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. **African** 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. þ 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 American If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify. Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 years College (1-4 or 5+) Private Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ulene Whitt Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6918 Northgate Parkway Clinton, MD 20735 Willistine Page - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 S Cremation 3 Removal from State Lee's Crematory Jan. 7, 2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Stewart Funeral Home Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between 20 Min Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2 NO Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗷 No 1 Tes 욘 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 X Natural Accident 5 Pending 2 🗆 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie AT2438946 I alebi On 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ebrahim Talebi Quje 6201 E. University Parkway, Baltimore 6MD/21218

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DEC. 29,02011 CROSBY Physician/ NAOMI FAYE 6:30 PM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL LUTHERAN HOME ROCKVILLE 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** (Month, Day, DEC. 3 Days Min. OHIO 465-14-2155 90 1921 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD. MONTGOMERY ROCKVILLE 1 X Yes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20850 USA 9701 VEIRS DRIVE death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 within 72 hours after Specify: WHITE 1 ☐ Yes 2 🔀 No Specify If Yes, Give 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry Decedent's Education permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) AT HOME HOMEMAKER 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, FLORA DEAN MILLER ည THOMAS SUTTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1001 CREEKSIDE, WINCHESTER, KY. KATHY C. STANG-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place MT • OLIVET CEM • 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1/4/2012 FREDERICK, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 2222-WISCONSIN AVE., NW 21. Signature of Funeral Service Lic HYSONG CO. WASHINGTON, the death. Do not enter the mode of dying, such as cardiac or respiratory arres Approximate Interval Between 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one case Onset and Death Immediate Cause (Final Ph. sician/ disease or condition UMUNI Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Dementa Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? 1 🗌 Yes 2 🗌 No 24 hours after death. Funeral Director: After this certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 K No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) the funeral Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 🖾 Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 - Homicide determined Hospital Medical 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2012 no JUAN AMY 00051158 Merer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 4:28 p. M Cynthia L. Cooper December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Davs 77 204-28-9356 1 🗆 M 💥 F Oct. 29, 1934 Pennsylvania **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10c. City, Town or Location notified at Director Laure1 1XXYes 2 No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ŏ iral", or items 23a or Examiner must be i Funeral USA 20724 3404 Littleleaf Place death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes Give Specify: "natural", 3 X Widowed 4 Divorced Completed Year or Dates. the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Medical 4 Pulmonary Tech other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental Fis marked of မ Nancy Westenberger Franklin J. Gingrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3404 Littleleaf Place, Laurel, Maryland 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra Denise Brenner - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 12-22-2011Frederick, Maryland Stauffer Crematory 4 Denation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Sign dure of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death weeks Immediate Cause (Final Hypoxic respiratory failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 2 weeks Hepatic Hydrothorax Sequentially list conditions, if ary, leading to min condecause. Enter Underlying Cause (Disease or injury that initiated events clie to for as a consectionce of: 1 year Exami End stage liver disease -tran and Due to (or as a consequence of): resulting in death) Last physician 10 years Physician/Medical Alcohol abuse death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atral fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an Aortic stenosis To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 a autopsy performed death?
1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2x No 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? Certificate: iniury 5 Pending 1 X Natural Accident
Suicid work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JOO 70427 trancis treisinger 5 30. Name and address of person who coopleted cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910

DHMH 17 Rev 06-2011

State

Registrar

Francis Freisinger, M.D.

 DFC

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygien	ne 2011 43202
			- Registrar	tificate of Death	Reg. N	
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-	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Columbia		Howard
	Funeral		Gilchrist Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
	Director		214-96-9199 1 □ M 2 🔀 F 99 Yrs.	Months Days Hours Min.	(Month, Day, Year Aug. 13, 19	
	, MC		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Lo	eation	Aug. 13, 13	912 Yugoslavia 10d. Inside City Limits
	ryland I-f show ied at	Director				1 ☐ Yes 2 😾 No
	r 28a notif	Dire	Maryland Howard Woodbir	10f. Zip Code	10g.	Citizen of What Country?
	with the		16006 Pheasant Ridge Court	21797		Croacia
	ems ems	Funeral	12 Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
ဖွ	ter de	by	1 Never Married 2 Married 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🛣 No Specify:	nican, etc.	Black, White, etc.
21215-0036	within 72 hours after death with the Maryland glene. et then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	ted	3 X Widowed 4 ☐ Divorced Year or Dates.			White
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Maryland	should be file and Mental I 7 is marked o raumatic eve	-		ng Address (Street and Number or Rui		
≥,′	and 2 s Health tem 27 i	- 1		6 Pheasant Ridge		dbine, MD 21/9/ Location - City or Town, State
lore	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho if item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at		I 1 Burial 2 Xi Cremation 3 Bertioval from State 21	matory or other place)		ŕ
Baltimore,	it. Pagintmer intant injury		4 Donation 5 Other (Specify) Stauffer 21. Signature Fungal Mortge Licenses	Crematory Inc. 12		ederick, Maryland.
Ва	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.	1	21. Signatural Pulled Service Licenses	2. Name and Address of Facility Stauffer Funeral F 621 Opossumtown P	Homes P. A. ike. Frede	rick,Maryland 21702
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	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Onset and Death		
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R	r: The ficate or, pag		25. Was case referred to medical	26, Place of Death (Che	1 Yes 2 V	No 1 ☐ Yes 2 No
/ita	sicial	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other		e 6V Other (Specify) HOSpice
Division of Vital Records, P.O.	g Phy er this neral c	e: To	27. Manner of Death 28a. Date of injury 28b. Time		28d. Describe how in	/
on	ath. r: Aft	Certificate:	2 Accident Investigation	M 1 Yes 2 No		
/isi	r Atterderrecto	erti	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
ă	urs af ral Di	alc		and all the state and all and	and due to the cause(c) and manner as stated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the death of t	stigation, in my opinion, death occurred	at the time, date and pl	lace, and due to the cause(s) and manner stated.
	orthin orthe	Σ	only one) 3 \(\subseteq Certifying Nurse Practitioner: to the best of my knowledge 29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	->-0		Below	D0060634	12	2/27/11
	,		30. Name and address of person who completed cause of death (Item 23a) (Type,			1 1
	0			WE COLUMBIA	A MD	21044
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature 33. Regist	backer		
	Registr	ar	OLU AU - 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12 Day 24 2011 10:01 P^M David Allen Crockett 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Frederick 612 East H Street Brunswick 8. Date of Birth (Month, Day, Year) 4/16/1956 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. Brownsville PA 1 XM 2 ☐ F Yrs. 165-46-5929 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2□No MD Frederick Brunswick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 410 East D Street 21716 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Schwans Salesman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mabel Irene Ball Carl Edward Crockett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 123 Quail Way, Hawthorne, FL. 32640 Carol Walters, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 文 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/2011 Hagerstown MD Hagerstown Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John T Williams Funeral Home, Brunswick MD 21716 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death pancratic cance Immediate Cause (Final Metastatic months disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown arteu ronnu 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Tes 26. Place of Death (Check only one)

Physician /Medical Examiner

the attending physician a hed for use as the burial-

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica

completely filled in by the funeral

Physician

/Medical

Examiner

Funeral

Director

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Funeral Director

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Certification:

Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-1 show

permit. Pages 1 and 2 should be filad Department of Health and Mental Hygie Important: If item 27 is marked other tannalic event. It any injury or other traumatic event. It and the content in the conte

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

25. Was case referred to medical examiner? 1 Yes 2No 27. Manner of Death 1 Natural

28a. Date of Injury (Month, Day Year) 5 Pendina investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 XOther (Specify Brothers 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

4 Homicide

3 Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAN-HING MO 31. Date filed (Month, Day, Year)

32. Registrar's Signature

610 9th AVE, BRUNSWICK, MD 21716

10×1 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:30 Mont December 30, 2011 Medical Franklin Conley 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1 Castle Hill Lonaconing Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign March 09, 1946 1 X M 2 - F Months Days Hours Min. Country Maryland 218-44-1098 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at **Funeral Director** Maryland Allegany Lonaconing 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a 1 Castle Hill 21539 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 10 **Delivery Driver News Distribution** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Conley Gertrude Kasel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health an Important; If item 27 is any injury or other trau Margaret Irene Conley - Wife 1 Castle Hill, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Gap Veterans Cemetery 20c. Location - City or Town, State Pateuary 03. 1 Burial 2 Cremation 3 Removal from State Flintstone, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} Men Medical resulting in death) ue to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy performed? Yes 2 No this certificate within 24 hours after death.

To the Funeral Director; After this certific.
completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 \square Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0040095 December 30, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 200 Glenn Street, Cumberland, MD George Pelligrino 31. Date filed (Month, Day 32. Registrar's Signature State

Registrar

Ple	ase Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	2011	1,3205
	State of Maryland / Department of Health and Mental Hygiene	2011	40200
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Physicia		Registrar 1. Decedent's Name (F	irst, Middle,Last	·)		timodio or				2. Date of D			3. Time of Death
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Funeral	4	5. Social Security Num			. Age (In yrs. la	ast birthday)	If Under 1	Year	If Under 24Hrs.	. 8. Date of	Birth(MN		thplace (State or
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72 hou	Completed	Elementary/Seconda		College (1-4		during m	ost of workin	g life. D	O NOT use reti	red)			^ .
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MD d 2 sho lth and n 27 is		Berthas	Elliott	-Mol	her	106 Cc	nomak	Ro	od, Ma	refield	like	st Virginia	2,26836
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Medical Examiner		Immediate Cause (Fin	al disease a.	Multiple Injur	ies								Death
xammoi	-1	or condition resulting i	n death)	Due to (or as a c	onsequence of	f):							
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Division Hospital or Attendit 24 hours after death. Fuoeral Director: A	Certification:	2 Accident 3 Suicide 6	Could not	be 28e. Place	of Injury - At h	ome, farm, stre	et, factory, o	ffice bu	ilding, etc.	or Tow	n State)		ural Route Number, City
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To the Hos within 24 h To the Fue	Medical	(Chock only	ertifying Physic edical Examine	r:On the basis of	examination a	ge, death occu ind/or investiga	ation, in my o	pinion,	death occurred	at the time, d	ate and	place, and due to t	he cause(s)
To wit To con	Me	29b. Signature and titl	e of certifier	and manner sta	1180		29c. l	icense	number		290	d. Date signed (Mo	onth, Day, Year)
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Regist	rar	OAN	J U LUIL	Lener	July hard	17							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43206 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 10:16 p M December Lawrence D. Chaney Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adevntist Hospital Takoma Park Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Jun. 26 Year) 1944 1 M 2 - F Months Hours Washington DC 67 **Director** 578-60-0116 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits irector X☐ Yes 2 ☐ No Mt. Rainier MD Prince George's ۵ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20712 4605 25th Street, Apt 4 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2.
If Yes, Give
Year or Dates 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Clerk National Geographic permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important; If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Beatrice Wilson Norman A. Chanev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice A. Peluso - Sister 2421 Kemper Road, Crofton, Maryland 21114 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Denation 5 Qther (Specify) Crematory 12-27-2011 Baltimore, Maryland Metro 22. Name and Address of Facility Beall Funeral Home Signature of Funeral Service License 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ MYO CARDIAL INFARCTION ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown ed by the a g Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed To the Hospital or Attending Physician: The lawitin 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 V 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 (Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 300 RIC D40324 DECEMBER 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

210

Registrar

State

TERRY JODRIE, MD, FACEP

DEC 2 7 201

31. Date filed (Month, Day, Year)

Registrar's Signature

7600 CARROLL AVENUE,

TAKOMA PARK, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 30, 2011 Physician/ December 3:30 AMWalter Otto Christ, Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Citizens Care & Rehab Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year, 1934 Washington, DC 1**⊠** M 2 □ F Hours Min April 19, Months Days 77 **Director** 577-44-1491 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral United States 21704 4520 Reels Mill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1952-55 1 Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Accounting Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ္ပ Dorothy Squitieri Walter Otto Christ, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) .0 1 and 2 s of Health item 27 i Dolores Christ / Wife 4520 Reels Mill Rd., Frederick, MD 21704 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Jan. 3, 2012 1 X Burial 2 Cremation 3 Removal from State Page Tent of injury or Frederick, Maryland 4 Donation 5 Other specify) 21. Signature of Fundral Service License Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. France he dise ..., or co shock, or heart fail ... List only ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or compl Approximate cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ asetes disease or condition Medical resulting in death) Due to (or as a conse **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ending physician and use as the burial-transit certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown the 9 Unknown P.O. by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I ģ plesin Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has death? 2 📈 No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DCA this completed filled in by the funeral ne Hospital or Attending Ph in 24 hours after death. ne Funeral Director: After th 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work's 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29b. Signature a 2 D0055061 who completed cause of death (Item 23a) (Type, Print) Ninh Street; Frederick, MD 2170

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 755 011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner 2014 Governor Thomas Bladen Way #201 Anne Arundel Annapolis 5 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 219-16-7888 Director 1 **X** M 2 □ F 3/23/1924 Maryland Usual Residence of Decede or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 23a Completed by Funeral 2014 Governor Thomas Bladen Way #201 USA permit. Page 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other transit 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 **X** Yes 2 □ No If Yes, Give 1 Yes 2 No Specify WWII Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Ocean Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harris Clotworthy Violet Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Douglas - Life Partner 1009 Bay Ridge Ave, PMBx 190, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Baltimore Crematory 12/22/2011 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Licer 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer De usopondosine Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, 24 hours after death. Funeral Director: After

Box 68760

P.O. I

ED 14H

State Registrar

Medical

29a. Certifier

only one 29b. Signature

31. Date filed (Mont)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

and title of certifier

Barry Meisenberg,

2003 Medical Parkway, #301, Annapolis, MD 21401

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

Amend #10E per AA Co. Dept	FC lc	1 1000	e Type or Prin								
AT W. OEAC		For State Registrar	State of Ma	-	epartment Certificate			Mental Hy	gien Reg. N	2111	43209
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Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	rector	10a. State 10b. County Virginia		10c. City, Town	or Location	Norf	o1k				10d. Inside City Limits 1 🔀 Yes 2 🗆 No
with the A	Funeral Director	10e. Street and Number 100 Fas 100 East Ocean	t View Avenue	05	10f. Zip 0	Code	2350	3	10g. C	Citizen of What Co	USA
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Ball permit Depar Impor any in		N 11.	aberty-								s, MD 21401
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: Te law "equires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal death	3 Ectopic pr 5 Other (spe		·		10	23d. Date of de Month	elivery Day Year
P.O P.O s that the strat the properties of the p	by PI	Part II. Other significant conditions	contributing to death bu	ut not resulting in	the underlying ca	ause give	en in Part I.				o the cause of death?
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Division of Vital I to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical									ce, and due to the	cause(s) and manner stated.
To the within To the somple	2	only one) 3 L Certifying Nu 29b. Signature and title of certifier	Tacutioner: 10 the	, Dear OF HIS KIRW		License		place, and due to		Date signed (Mon	
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16		30. Name and address of person who			iype, Print)	lica	2 (was A	000		1 21401
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 30, 2011 Physician/ 9:10 A M Howard Souder Carroll Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Denton Homestead Manor 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 1 X M 2 □ F **Funeral** Months Days Hours Min. 0872971931 Pennsylvania Director 207-26-4487 80 Usual Residence of Decedent show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Sant If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🔀 No St. Michaels Talbot Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21663 7195 Solitude Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. 3 X Widowed 4 ☐ Divorced White Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 18b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial pilot Airline pilot 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Souder E11en Francis Carrol1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) St. Michaels, MD 7195 Solitude Road Amy Carroll/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/31/2011 Capitol Crematory Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Moore Funeral Home, P.A. Signature of Funeral Service Licent 12 South Second Street Denton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Parkmans Immediate Cause (Final disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached if ☐ Yes ∠ ☐ ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed2 1 Yes 2 No 1 Yes 2 No After this certificate 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Hospital: Other: 4 \(\to\) Nursing Home 5 \(\to\) Residence 6 \(\overline{O}\) Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 🗌 No Investigation Accident after death filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

completed

within 2

31. Date filed (Month, Day, Year) JAN 04 Registrar

melinda

(Check

only one)

3 🗆

29b. Signature and title of certifier

3683 Chaptenk Rd 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0005325

3011

Preston MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: Telaw requires that the death certificate be executed e Funeral Director: , etely filled in by the fi 24 hours after death. the

> 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Assistant Medical Examiner

and manner stated

30. Name and address of person who completed cause of death (tem 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

Medical

State Registrar

29b. Signature and title of certifie

Zabiullah Ali, M.D.

29d. Date signed (Month, Day, Year)

January 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per PHY G923 1/19/2012 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner saltimore NIA ouldin Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min 60-78 1 🗆 M 2 🔀 F Director 3 Yrs. 1952 show Department of Health and Mental Hygiene. Important: if items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21205 Bould 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black 3 🗌 Widowed 4 🗎 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled sabled Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ elores a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abingdon ontee-Daughter ર્રફ Allison 0 10 Wa 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 11/18/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Helpmohn permit. E. North Ave 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 Sport Milan Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final oronar UY Ph sician/ disease or condition Medical resulting in death) Due to (or as a consquence of) **Examiner** Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-transit and as a attending physician Physician/Medical requires that the death certificate be # λ ያው Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ģ in the past 12 months? Month Dav Year Pregnant at time of death
Unknown detached the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause dven in Part 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5XXResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 \sum Yes 2 \sum No 1 Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Date signed 1/2/1/8/4201/ 29d. 29b. Signature and title of certifie 30. Name and address of person who comp d cause of death (Item 23a) (Type, Print) 32. Registra State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep	artment of Health and Mental Hygiene	
			tificate of Death Reg. No. 2011 432	13
Physicia	n/	1. Decedent's Name (First, Middle, Last)	2. Date of Death December 27, 2011 3:35	
Medic	al	Kim Insoon Demmitt		ĿM
Examin	er	4a. Facility Name (if not institution, give street and number) 11738 Wolf Lane	4c. County of Death Williamsport Washington	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or For	reign
Director		219-64-3203 1 M 2 X F 62 Yrs.	Months Days Hours Min. March 6,1949 South Korea	
ow t	L	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L-	cation 10d. Inside City Lin	- ita
ırylanı I-f sh ied a	cto			- 1
or 28a notif	Dire	Maryland Washington	Williamsport 1 Uses 2X 10f. Zip Code 10g. Citizen of What Country?	27.10
with the 23a c	eral	11738 Wolf Lane	21795 USA	
eath tems er mu	Funeral Director		Was Decedent of Hispanic Origin? (Specify Yes or No-	
offer of ", or i	by	1 Never Married 2 Married 1 Yes 2 No	· □ · · · · · · · · · · · · · · · · · ·	
2-UUSO 2 hours after "natural", o	Completed	3 U Wildowed 4 U Divorced Year or Dates.	ASIGN	
72 hc	n plan	(Give	Jent's Usual Occupation Jent's Usual Occupation Aind of Work done during most of working O NOT use retired	
AILAI within 73 giene. er than the Me		Elementary/Seconday (0-12) College (1-4 or 5+)	Owner Restaurant	
filed all Hy doth	Be c	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)	
yiand lid be filec Mental Hi narked otl latic even	욘	Pong Chae Kim	Pam Kum Kim	
Mar 2 shou th and 27 is n traum			ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
and 2 Healt Hem 2 ther		William Demmitt - Husband 1173 20a. Method of Disposition 20b. Place of Disp	8 Wolf Lane Williamsport, Maryland 21795 sition (Name of Date 20c. Location - City or Town, State	
age 1 ant of int: If ii		1 Burial 2 Cremation 3 Removal from State cemetery, cre	natory or other place) Cemetery Dec.30,2011 Hagerstown, Marylan	ا ہ
Dalitimore, IMaryliand Z I Z 13-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once.			sbottle funeral Home, P.A. 21795	<u> </u>
Departi Departi Impograny in		New Col Mi	25 S. Conococheague St.Williamsport, Marylan	a
		23a and 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		
Priysician/		Immediate Cause (Final disease or condition	Onset and Death	h
Medical Examiner		resulting in death) Due to (or as a consequence of):		
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):		
ted I nsit	m in	Cause (Disease or imjury		
execu an and ial-tra	dical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
requires that the death certificate be executed requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dica	d		
entifica ding ph	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		
death ce	Physician/Med	in the past 12 months?	Ectopic pregnancy 23d. Date of delivery Other (specify) Month Day Year	7.7
he deay the graph of the graph	hysi	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	S Other (speediff)	
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us, quires en sig	ted		1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unkr	nown
e Cords, e law requires has been sig	Completed		24a. Was an autopsy 24b. Were autopsy findings avails prior to completion of cause	
The I	Con		performed? death? 1 Yes 2 No 1 Yes 2 No	
VILCII ysician: s certific	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only one) Other:	
ding Physician: The le hand the this certificate he funeral director, page	ر ا	1 Yes 2 No Pospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of	nt 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
nding tth. : After	cate	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 Yes 2 No	
VISION or Attendir frer death. irector: Af	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		
ital or all bir all bir led in		building, etc. (opecity)	City or Town, State)	Į,
Hosp 24 hou Funer	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inve	occured at the time, date and place, and due to the cause(s) and manner as stated. tigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner	stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ž	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)	
F S F O		Muhay Melowel Me		
		30. Name and address of person who completed cause of death (Item 23a) (Type.	Print)	
W-0		Michael Mclornack IIIIo Me.	back lamper tragerstown MO.	
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	backer	
nogistic		DEC		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43214 For State Registrar AMEND#19apear FH, 1/4/12; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Bernice A. Dickinson 6/1 7:55p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Spring Montgomery Silver Social Security Number 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Yea, April 10, 1 M 2 XF 93 Director 226-22-0901 Virginia 1918 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 ¥ Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1309 Roxanna Rd. 20012 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2 X No Completed by 1 ☐ Yes Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. **Federal** Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Staff Assistant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gurney C. Anderson Carrie Beverly Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; If item 27 is 1 any injury or ... Barbara S. Wynn 1634 Myrtle St. NW WAshington, DC 20012 -daui Saltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12/23/11 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Brentwood, Md Signature of Funeral Service 22. Name and Address of Facility McGuire Funeral Service Inc. 7400 Gegorgia Ave. NW Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Respiratory Failure Medical resulting in death) Due to (or as a consequence of Examiner Pneumonia Sequentially list conditions, if any, leading to immediate E to Trying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Signal Signal Acute Coronary Syndrome and that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical CHF Box 68760 as t IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo for 5 Other (specify) Pregnant at time of death the a 1 ☐ Yes ∠ □ 9 ☐ Unknown q I Inknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by В 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Records, Dysphagia Completed 24b. Were autopsy findings available 24a Was an Morbid Obesity autopsy performed? Yes 2 X No prior to completion of cause of death? certificate has page 2 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 XNo ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this vithin 24 hours after useau..

To the Funeral Director: After th 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: (Month, Day, Year) X Natural 5 \square Pending 1 Yes 2 No Acciue
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number Rohmanion December 23, 2011 D66372 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Majid Rahmanian Shahri, MD 1500 Forest Glen Rd. Silver Spring, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month December 2011 10:45 AM[™] L. Medical Martha Dohm 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Kline Hospice Airy 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min Month, Day Ye 1939 411-62-4554 **Director** 1 🗆 M 2 🕱 F Tennessee 73 Usual Residence of Deceder 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Maryland Walkersville Frederick 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 8762 Beacon Circle 21793 United States or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "in any injury or other traumatic account." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government <u>Administrative Assistant</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Raymond Martin Couch Evelyn Turnbull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Therese Fryer / Daughter 103 E. Seventh Street Frederick, Maryland 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) December 4 ☐ Donation 5 ☐ Other (Specify) Etlan Cemetery 30, 2011 Etlan, Virginia 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician I for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day Year signed by the a 1 ☐ Yes 2· 9 ☐ Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has l autopsy perform 2 🗌 No certificate 1 🗌 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Time Hes MICE 1 Tyes Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 65 Shah 31. Date filed (Month, Day, Year) Registrar's Signature 32 State 9 Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible TM 1/4/12 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Dec. 24, Decedent's Name (First, Middle, Last) 2011 Time of Death Physician/ Month 5:05p Carol A. Derk Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Kline Hospice House Mt. Airy Frederick Birthplace (State or Foreign Country) If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 220-50-5824 Director 1 □ M 2 🗗 F 62 11/17/1949 MD Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 ☐ Yes 2 🗷 No MD Frederick Frederick r must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 511 Logan Street USA 21701 death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ò 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify. "natural" 3 Widowed 4 N Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the correction officer 5+ 1aw Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I of Health and Mental fitem 27 is marked မ Gretchen Virginia Neal David T. Gregg 19a. Informant's Name/Relationship (Type Print)/ Edward D. Derk, Jr./ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Logan Street, Frederick, MD 21701 Darryl Derk, Jr./son altimore, other 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2 🖾 Cremation 3 🗌 Removal from State cemetery, crematory or other place, ö Department in Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2011 | Frederick, MD Stauffer Crematory 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the dise shock, or heart failur ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Metastoric 3mall Cell 1 monte disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year Pregnant at time of death the 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 Yes 2 No Yes 2 No the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 V No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier December 27,201 1 and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 46 & Thomas Johnson Dr ste 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible 1918. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $20\overset{\text{Yea}}{1}$ Caro1 Ann Douglas December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George Doctors Hospital Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Days Hours Min Maryland 1 🗆 M 2 🗓 F 12/4/195 213-70-9450 54 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Directo Maryland | Prince George Upper Marlboro 1 - Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 10459 Campus Way South USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. <u>م</u> 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72.1 and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clifton Alexander Marjorie Sterling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health an
Important: If item 27 is 1
any injury or an 10459 Campus Way South, Upper Marlboro, MD 20774 Eric K. Douglas/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel AME Ch. Cem. 1/2/2012 Cambridge, MD 21. Signatur 22. Name and Address of FacilityGeorge P. Kalas Funeral Home f Funeral Service Licensee 6160 Oxon Hill Rd. Oxon Hill, MD 20745 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Cardiopulmonary Collapse disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Severe Pulmonary Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Exami the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.

The law requires that the certificate has been signed by the attending physician and releted filled in by the funeral director, page 2 should be detached for use as the burial-transit Sickle Cell Disease that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Deep Venous Thrombosis IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? Accident Investigation 2 Acciden 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the comple only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rointan Farahi-Far, M.D. 12700 Goodloes Promise Dr., Bowie, MD 20720 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State parke DEC 2 9 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 December 3:05 A M SARAH DOLAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours May 22, 1936 114-28-2689 75 New Jersey **Director** Usual Residence of Decedent show 10h County 10a. State 10d. Inside City Limits notified at 10c. City. Town or Location Director 28a-f Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be items 23a Funeral 1421 Taney Avenue, Apartmenbt 112 21702 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. ö Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: "natural", White Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Jordan Dorothy White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce, Margaret I. McKinney / Daughter 358 East Third Street, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 3, 1 Burial 2 A Cremation 3 Removal from State Smithsburg Maryland Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service 22. Name and Address of Facility **Keeney < Basford P.A. Funeral Home** M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line erval Between Onset and Death Immediate Cause (Final Respination Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ► No Pregnant at time of death 1 ☐ Yes ∠ p 9 ☐ Unknown Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy Yes 2 No 2 🗌 No 1 🗌 Yes Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ၉ 1 Tes 2 XNo 1 Minpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) e Hospital or Attending Ph n 24 hours after death. e Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

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State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Pretime Ubndey:

PRATIMA PANDE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MDD 64910

400 West Seventh Street, Frederick, Maryland 21701

29d. Date signed (Month, Day, Year)

12-31-2011

11-09781 Amy Dovle Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

my Doyle	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No.										
Physician/ Andical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Pear December 29, 2011 3. Time of Death 0330 hrs										
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Shock Trauma 4c. County of Death Baltimore										
Funeral Director	5. Social Security Number 212-13-0372 6. Sex 1 Age (In yrs. last birthday) 41 Yrs. 1 Under 1 Year If Under 24Hrs. 1 Under 1 Year If Under 24Hrs. 1 Under 24Hrs. 1 Under 1 Year If Under 24Hrs. 1 Under 1 Year If Under 24Hrs. 1 Under 24Hrs. 1 Under 1 Year If Under 24Hrs. 1 Under 24Hrs. 1 Under 24Hrs. 1 Under 1 Year If Under 24Hrs. 2 Under 1 Year If Under 24Hrs. 3 Under 1 Year If Under 24Hrs. 4 Under 24Hrs. 4 Under 1 Year If Under 24Hrs. 4 Under										
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits										
viaryland 28a-f show d at once. ector	MD Anne Arundel Millersville 1 ☐ Yes 2 ☒ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?										
eath with the Maryland items 23a or 28a-f sho- ust be notified at once, aneral Director	606 Wheat Mill Court 21108 USA										
후 등레 교	11. Marital Status 1 Never Married 2 Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 1 Yes 2 No 2 No specify: 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White, etc. White										
5-0036 led within 72 hours after death with the Maryland Tygiene. other than "matural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher's Aide 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher's Aide Education										
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MD 21 12 should 1 th and Mer 127 is man umatic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 170 Hayden Road Millersville, MD 21108										
s I and free Heal	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens 20c. Location - City or Town, State January 3, 2012 Davidsonville, MD										
Baltimo permit. Page Department of Important: injury or oft	21. Signature of Furneral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146										
Physician	23a. Par(1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
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ox 687(ath certifica attending pl or use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23d. Date of delivery Month Day Year										
i, P.O. Be fres that the de signed by the I be detached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown										
of Vital Records, Is Prysteian: The law requires ther this certificate has been signeral director, page 2 should be 1: To Be Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No										
Physician: The rath is certificate ral director, page To Be Con	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Very Other. Scene										
− ∄ਾਨੂਟੀ ਨੇ	27. Manner of Death 1 Natural 5 Pending 2 Accident Protestigation 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No Driver auto fixed object collision										
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune ledical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street 28f. Location (Street and Number or Rural Route Number, City or Town, State) 176 Dorsey Road, Hanover, MD										
To the Hos within 24 h To the Fun completely	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
€ 60 ×	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 29, 2011										
5	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223										
State	31. Date filed (Month, Day, Year) 3012 32. Rigistrar's Signaturé										

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Physici		Registrar 1. Decedent's Name (First, Middle,Last)	Cerano	ale of Deal			2. Date of Deat		3. Time of Death		
Andical Exami		NKONOU AYAONI EDO	SCH				Month December	Day Year 28, 2011	1634 hrs		
		4a. Facility Name (if not institution, give street and number)				Location of Death		4c. County of			
		Route 355 @ Elsmere Avenue			Sprin	•		Montgome			
Funeral Director		5. Social Security Number 6. Sex 7. Age (NON€ 1 № 2 F	In yrs. last birt 49	thday) If Undo Month Yrs.	s Day		/	1962	9. Birthplace (State or Foreign TO 60 Country)		
		Usual Residence of Decedent					-/-		10d. Inside City Limits		
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yland -f sho	ġ	10e. Street and Number	DILVE	R JPRI	Code		110	Og. Citizen of What			
e Mar or 28s	Director	MD MONTGOHERY : 10e. Street and Number 14223 GEORGIA AVEN.	· · · ·	101. Zip) h G	-6	"	TO 60	Journal V.		
5-0036 led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent E				spanic Origin? (Sp	ecify Yes or No		American Indian, Black,		
eath w items	Funeral	1 Never Married 2 Married Armed Forces?	No			, Mexican, Puerto		White,	etc.		
fter d		3 Widowed 4 Divorced If Yes, Give Year or Dates:	i No	1 Yes 2	No	specify:		Specify: Z	BLACK		
11215-0036 Id be filed within 72 hours af fental Hygiene. narked other than "natural event, the Medical Examin	d by	15. Decedent's Education (Specify only highest grade compl		Decedent's Usual during most of wor				16b. Kind of Busi	ness/Industry		
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	9	19a. Informant's Name/Relationship (Type, Print)				et and Number or F	Rural Route Num	ber, City or Town,			
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Baltimore, permit. Pages 1 at Department of Hes Important: If ite injury or other tr	ı	21. Signature of Funeral Service Licensee	P	22. Name and	Address	s of Facility B	WCHI 1	FUNERAL	SERVICE, LLC		
W 50 11		23a. Part I. Enter the disease, occomplications that caused th		814 01	5Hz	IR STRE	ET, NW.	WASHING	TON DC 20021		
Physician /Medical	0	23a. Part I. Enter the disease, occomplications that caused th failure. List only one cause on each line.	e death. Do n	ot enter the mode	of dying,	such as cardiac o	r respiratory arri	est, snock, or nean	Detween Onset and		
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	wanta of						Death		
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	aminer	cause. Enter Underlying Cause (Disease or injury that initiated expects resulting in death). Last Due to (or as a conseq	uence of):								
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exe ian	lical	UNPENDED AMENDED									
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ox 687 eath certific attending	ian	23b. Was decedent pregnant in the past 12 months?		Fetal death Other (Spe		Ectopic pregna	ncy	Month	Month Day Year		
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tal Re-		25. Was case referred to medical			26.Place	e of Death (Check					
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ion of Vital tending Physician: eath. tor: After this certifi the funeral director,	n: T	27. Manner of Death 28a. Date of Injury	28b.	Time of Injury 8 hrs		iry at Work?		now injury occurred auto to			
	Certification:	2 Accident Investigation				Yes 2 No					
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fil on		4 Homicide						Elsmere Avenue			
Divis To the Hospital or A within 24 hours after or To the Runeral Direct completely filled in by	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my lone (Check only one) Medical Examiner: On the basis of examiner)	knowledge, de ination and/or	ath occurred at the investigation, in m	y opinior	ate and place, and n, death occurred a	t the time, date	and place, and du	s stated. e to the cause(s)		
To T	Med	29b. Signature and title of certifier				se number			(Month, Day, Year)		
		In a the wall min			O.C.	M.E.		December 2	9, 2011		
		30. Name and address of person who completed cause of dea	ath (Item 23a)								
R5		Pamela E. Southall, MD Assistant Medic	al Examine		altimor	e Street, Balti	more, MD 2	1223			
	tate	31. Date filed (Month, Day, Year) 32. Registrary	Signature	41							
Regis	trar	OTHER TAUL CLASSE &	· Marie								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wayne Edens Billy 2011 December 10:07A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's Laurel Social Security Number 8. Date of Birth (Month, Day,) May 14 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday, Hours 1 🛛 M 2 🗆 Maryland **Director** 57 216-64-7312 1954 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director MD Montgomery Silver Spring 1 Yes 2 Yo 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 15808 Thompson Road 20905 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 2 🗵 No 1 ☐ Yes 2 🗷 No Specify: Specify: White 3 Widowed 4 M Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) f Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N 12 0 Car Detailer Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Μ. Edens Helen J. Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James K. Edens / Brother 9005 Ewing Drive, Bethesda, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 1/2/2012 Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Hypoxia Medical Due to (or as a consequence of): **Examiner** Acute Respiratory Failure Sequentially list conditions, if any, leading to immediate outse. Enter Undanying Examine Due to (or as a consequence of): Septic Shock To the Hospital or Attending Physician: Te law equires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): inding physician ause as the burial-Physician/Medical Metabolic Acidosis Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal deat
Pregnant at time of death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown care has t een sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 🗌 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗹 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending s after death. 1 Tes Investigation 6 Could not be 2 🗌 No Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical within 24 hour To the Fune completed file 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MID

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zorayda M. Lee-Llacer, M.D.

3 0

D 12962

7300 Van Dusen Road, Laurel, MD

29d. Date signed (Month, Day, Year)

20707

January 1, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28 Physician/ Robert Richard Eichelberger Month December 7:46 РМ 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 XM 2 🗆 Days Hours Min 11-28-1941 **Director** 215-42-2891 Usual Residence of Decedent show 3a or 28a-f shov t be notified at 10b. County the Maryland 10c. City. Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🎛 No MD Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral r items 23a iner must be permit. Page 1 and 2 should be filed within 72 hours after death with 12721 Layman Road 21788 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? ò \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔣 No Specify: "natural", ^{Specify:} White 3 Widowed 4 Divorced Completed Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Spreader Sewing Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John David Eichelberger Edna V. Cline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Eichelberger, Jr. - Son 12721 Layman Road, Thurmont, Maryland 21788 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mt. Prospect Cemetery 1-3-2012 Lewistown, Maryland Signature of Funeral Ser 22. Name and Address of Facility Robert E. Dailey & Son F.H., P.A. KaNTE 615 East Main Street, Thurmont, Maryland 21788 23a. Part 1. Enter the disease, or ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final et and Death Physician/ disease or condition resulting in death) MOXIX Medical Due to (or as a consequence of): Examiner Card 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of attending physician and for use as the burial-transil Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Funeral Director: After this certificate has eted filled in by the funeral director, page 2.9 performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending (Month, Day, Year) Vatural Accident 5 Pending work death. Investigation 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1475

State

Registrar

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland / I		ment of Hicate of D		nd Mental Hy	giene	011	43223	
			Registrar 1. Decedent's Name (First, Middle, Las	2 Date of D	rieg. No.								
L	Physicia Medi		Thomas Allen	Footen					Decemb	Dav	3. Time of Death 7:50 A M		
C	Exami	ner	4a. Facility Name (if not institution, give 24404 Pine Hill 1			41:	o. City, Town, or I Rawlir		Death		nty of Death		
	Funeral		5. Social Security Number 6. Se	7. Ag	e (In yrs. last birt		Under 1 Year onths Days	If Under 24		th	9. Rirth	place (State or Foreign	
à	Director		220–15–5500 Usual Residence of Decedent	⊠ M 2 □ F	85	Yrs.	Ontris Days	Hours	Aug. 3	0, 1926	Mar	yland	
	yland -f shov ed at	ctor	10a. State 10b. County Allegar	nv	10c. City, Towr	or Location						10d. Inside City Limits	
	he Mar or 28a	Dire	10e. Street and Number	-1	Raw		0f. Zip Code			10g. Citizen o	of What Cou	1 Ves 2 No	
	is 23a	Funeral Director	24404 Pine Hill	Road			2155	57			ed Sta		
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.		If Yes	Decedent of His s, specify Cuban Yes 2 X No	, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	В	ace - Americ lack, White, ify: Whit	etc.	
15-(72 hou n "natu Aedica	Completed	15. Decedent's Ed (Specify only highest gra		16a.	Decedent'	s Usual Occupat of work done du OT use retired)	tion ring most of	working	16b. Kind of	Business/In	ndustry	
	within giene. ier tha		Elementary/Secondary (0-12)	College (1-4 or 5	+)	Barte				Tave	rn		
Maryland	should be filed within 72 h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med	To Be	17. Father's Name (First, Middle, Last) Thomas Foote	n					Name (First, Middle izabeth Di		me)		
	ind 2 shoulealth and im 27 is in her traum		19a. Informant's Name/Relationship (Ty Thomas Footen/son	pe, Print)				nd Number of 1 Road	Rural Route Number d, Rawline	r, City or Town, Js, Mar	, State, Zip (yland	21557	
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		20b. Place of cemeter	Disposition of Disposition of Cland	n (Name of ry or other place, Cremato	ry 12,	Date /31/2011	20c. Location	-	own, State Maryland	
Bal	permit Depar Impor any in	1	21. Signature of Funeral Service License	Bal					Boal Fund Westernpo			21562	
إساس	h, sician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each line	the death. Do n	ot enter the	e mode of dying,	such as card	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death)	The state of the s	consequence o	L	9,				X	>5ueno	
	ed isit	Examine	Sequentially list conditions, if any hading terminoles cause. Enter Underlying Cause (Disease or injury	1.1	reonesquaries o							> ()	
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09	ate be executed ohysician and the burial-transit	edical		d									
09/89	pertifica nding puse as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy					224 [Date of delive	001	
). Box	the death by the atter ached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth : 4 ☐ Pregnant at 9 ☐ Unknown			topic pregnancy ner (specify)				Ionth	Day Year	
ds, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. The Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	þ	Part II. Other significant conditions co	Severe	t not resulting in	n the under	lying cause giver	n in Part I.		obacco use cor Yes 2 No		ne cause of death?	
Division of Vital Records,	rsician: The law re s certificate has be director, page 2 sh	Completed	Anemia COPD						24a. Was autoj perfo 1 🗌 Yes	rmed?	prior to completion of cause of death?		
ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	lospital:			Other		Check only one)			**	
n of V	iding Phys th. After this funeral di	cate: To	27. Manner of Death 1 Natural 5 Pending	1 L Inpatie 28a. Date of injur (Month, Day,	nt 2 ER/Out y 28b. Ti Year) in	ime of jury	28c. Injury a work?	t	g Home 5 Residence 1 Residence 1)	
ivisio	I or Attendii after death. Director: Al d in by the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	ry - At home, fari (Specify)	M 1 ☐ Yes 2 ☐ No ome, farm, street, factory, office 28f. Location (Street and N City or Town, State)						Route Number,		
ш	of the Hospital or Attending Physiciam: within 24 hours after dealth. To the Funeral Director, After this certificacompletely filled in by the funeral director,	Medical	29a. Certifier (Check conly one) 1 Certifying Physical Examination (Check conly one) 2 Certifying Nurse	er: On the basis of ex.	amination and/or	investigation	on, in my opinion.	death occurr	ed at the time date a	nd place and di	ue to the car	ise(s) and manner stated	
	To the within To the comple		29b. Signature and title of certifier	2,004.	M.D.	J-, wast	29c. License n	umber		29d. Date signe			
	at	VA	30. Name and address of person who co	impleted cause of de	ath (Item 23a) (Ty	1-1	enn St	11 1 1	imber 6.	I wir	21.	502	
i	Stat Registra	-	31. Date filed (Month, Day, Year) JAN - 3 2012	72. Registrar	's Signature	arke	1		-17.0-01	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gertrude Klein Friedman 2011 December 12:05 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Chevy Chase 5480 Wisconsin Avenue Apt. 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 577-48-9319 Director 1 🗆 M 2 😾 F 99 01/10/1912 New York Usual Residence of Decedent or 28a-f show a notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Chevy Chase Montgomery 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be i Funeral United States 20815 5480 Wisconsin Avenue Apt. 522 items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 2 XNo Yes If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced er than "nature, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) of Health and Mental Hygiene.
If item 27 is marked other that or other traumatic event, the N College (1-4 or 5+) Administrative Clerk Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rose Hollander Jacob Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Orgel / Nephew 10617 Amherst Ave. Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 12/26/2011 Falls Church, VA King David Cemetery 21. Signature o Funeral \$ 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Examine Due to (or as a consequence of) and I-tr_nsit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): for use as the burialattending physician Physician/Medical requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 Yes 2 X No Pregnant at time of death Month signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law page 2 has autopsy perforn within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Other: ဂ္ 1 🗌 Inpatient 2 🗆 4 Nursing Home 5 X Residence 6 Other (Specify) ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending ☐ Accident☐ Suicide 1 Tes 2 🗌 No Investigation completely filled in by the 6
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) D29353 12/23/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George W. Graves MD 5530 Wisconsin Ave. #1400 Chevy Chase, MD 20815 31. Date filed (Month, Day, Year, State Registrar's Signature barles **DEC 27** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registra MEND#28e+fperDME, 12/27/11: PMI, MCC Certificate of Death 1. Decedent's Name (First, Middle, Last) Date Month 2. Date of Death 3. Time of Death Physician/ OLOI AM YABLO ALEJANDRO Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN BETHESDA MONTGOMERY HOSPITAL MD5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1**X**M 2 □ F Months Days Hours none Argentina Director Usual Residence of Decedent show 10a. State notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Montgomery 1 Tes 2 No Rockville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a o Examiner must be 806 Bowie Road 20852 Argentina 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 X Yes 2 □ No Specify: South "natural", Completed 3 Widowed 4 Divorced Year or Dates White American Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dancer Entertainment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Atilio Fontana Alicia Zulema Salvide 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other transones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Atilio Fontana. Father 806 Bowie Road. Rockville. Maryland 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Crematory 12/26/2011 Baltimore, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee MO1102 1040 Rockville Pike. Rockville. Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Retroperationeal disease or condition resulting in death) Hemorrhage Medical Examiner hours Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) oagulopath hours that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical UEHKLE 2100 cocelsca IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant a Month Pregnant at time of death Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform After this certificate I Yes 2 No 1 🗆 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending thin 24 hours after death. 1 Natural
2 Accident
3 Suicide 5 Pending 2100 PM within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 12/17/11 1 Yes 2 No Investigation MOTUR UEHILLE (OLUSIUN 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc., (Specify) Street 28f. Location (Street and Number of Rural Route Number, Rd. No. State St. Clube Dr. & Reognite Rd. determined Maryland Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number MD 12-18-11 D64058 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WHITTAKER R. DAVID 8901 Wisconsin Ave; Bethesda, MD 20889 31. Date filed (Month, Day, Year) 32. Registrar's Signa State Registrar

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2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\int\) 43226 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Violet December Bennett Fitzgerald 26 2011 1:00 p. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Woods Center Cambridge Dorchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Hours 214-36-5627 Director 73 1938 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits MD Dorchester Cambridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2908 Sloop Road 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. white Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 th and Mental Hygiene.

7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) line worker electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Bennett other traumatic Ruth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sandy McCollister daughter 5428 Hicksburg Rd., East New Market, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Crematory of Delmarva | 12/28/11 4 ☐ Donation 5 ☐ Other (Specify) Delmar, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause of ach line Interval Between Immediate Cause (Final One I and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician if or use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 🗗 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of eause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 L Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to gledical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical 1 L'Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2 8 address of person, who completed cause of death (Item 23a) (Type, Print) ae and /VAP 100 Bramble 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 30 2019ia 7:00 Donald Ralph Fazio Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County 22 Redwood Circle Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 232-58-6403 73 Director 1 🛛 M 2 □ F Aug. 27,1938 West Virginia or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington County Hagerstown 1 ☐ Yes 2 X No ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı Funeral U.S.A. 22 Redwood Circle 21740 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", other traumatic event, the Medical Exar 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) District Manager Retail Grocery 2 should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nick Fazio Frances Napolillo Fazio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Redwood Circle Hagerstown, MD 21740 Nancy Louise Fazio-wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or otl Beverly Hills Mem. Gardens 1 X Burial 2 Cremation 3 Removal from State 1-5-2011 Morgantown, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home re of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical (or as a consequence of): **Examiner** mentially list care Winnes Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last attending physician a I for use as the burial-Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the a Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform certificate 2 No 1 🗌 Yes Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 7 NO Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗌 Nursing Home 5 🗖 Residence 6 🗌 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completely filled To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00564 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 3 Saxen State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 746 MAURICE 701 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🛣 M 2 🗆 F Hours (Month, Day, 1 ^{/ear} 1969 Wash. D.C. **Director** 42 215-86-9760 Jan. Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1364 Salem Avenue 21740 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces <u>م</u> Black, White, etc. 1 ☐ Never Married 2 🔀 Married 2 X No Baltimore, Maryland 21215-0036 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: Completed Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Sales 0 Car Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rhonda Laverne Parker Robert Wilbert Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1364 Salem Avenue, Hagerstown, Maryland 21740 <u> Jennifer E. Graves - Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Hagerstown Crematory 12/30/2011 Hagerstown, Maryland permit. 21. Signature of Funeral Service Licer 22. Name and Address of Facility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Henno hale disease or condition Medical resulting in death) **Examiner** 0 sequentially list outside in, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) -transit the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death signed by the a ld be detached f Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ After this certificate has been si funeral director, page 2 should? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗌 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1/2 No Other: မူ 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending death. Accident Investigation 1 🗌 Yes 2 No To the Funeral Director: completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 701 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tageistown, MD 21740

Registrar DHMH 17 Rev 7/2009

State

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MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. = For State Registrar State of Maryland / Department of Health and Mental Hygiene 43229 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Kenneth Richard Gray Sr. December 1820 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year 124) Social Security Number 6. Sex 1 Å M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 67 Yrs. Director 577-56-4218 1944 Usual Residence of Decedent 28a-f show 10b. County **Funeral Director** 10a, State 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at 1 🏻 Yes 2 🗆 No DC Washington 0 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a 20018 United States 3298 Fort Lincoln Drive NE filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify. Black Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha 12th Driver Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Siberia B. Gray Thomas Cary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6111 Red Squirrel Place Waldorf, Maryland 20603 If item 27 Kenneth Davis - Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ott once. Date January 9, Lee's Crematory Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funtial Service Licenses Im 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TICEMIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ç Month Year Pregnant at time of death Dav been signed by the should be detached Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s performed 2 🗌 No Yes 2 No 1 Tes Division of Vital funeral director. 25. Was case referred to medica 26. Place of Death (Check only one) examiner's Hospital Other: 2 🔀 No 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury I or Attending P Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending ithin 24 hours after death.

the Funeral Director: After completed filled in by the fun 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 43230 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201^{Year} 3, December 6:36 PM M Marion E. Gross Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4019 Frankford Avenue Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Davs Hours 88 215-18-9436 **Director** 1 □ M 2 🛣 F Vrs Maryland Usual Residence of Decedent 4/25/1923 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore ems 23a or 2 r must be no 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21206 4019 Frankford Ave. items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or ite Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) food industry meat wrapper event, th Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic even 18. Mother's Name (First, Middle, Maiden Surname)
Carrie Fleckenstein မ George Joseph Rosch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Linda Gross - daughter 4019 Frankford Ave; Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ÷ 5 Department or Important: If any injury or once. Funeral Service Lice Rona d 8 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Myocazoral Medical Due to (or as a consequence of) **Examiner** ATTHENOSCI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to or as a consequence of and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a Medical Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery cate has l

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 filled in by the funeral director, Director; After this within 24 hours a

To the Funeral C

completely filled

1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day Year								
Part II. Other significant conditions		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
	per	s an opsy findings available prior to completion of cause of death? 1								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 Yes 2 Yo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔀 Res	sidence 6 Other (Specify)								
27. Manner of De th 1 Anatural 5 Pending 2 Accident Investigation	on (Month, Day, Year) Injury work? M 1 \[\text{Yes} 2 \[\text{No} \]	how injury occurred								
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Location	(Street and Number or Rural Route Number, own, State)								
(Check 2 Medical Exar	ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date urse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to	and place, and due to the cause(s) and manner stated								

29d. Date signed (Month, Day, Year) 2017

2(23)

Parkville

DHMH 17 Rev 06-2011

State Registrar

မ

29b. Signature a

31. Date filed (Month, Day, Year)

s of person who completed cause of death (Item 23a) (Type, Print)

8109 ITARFORD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene per me, g923,01/12/2012dhb Certificate of Death 4323 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Michael 6 (Tray Medical 301 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Maryland Baltimore Medical Center 25 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country **Director** 1 M 2 - F Marylan 96 28a-f show and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shouther traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ✓Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 22 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces' Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 2 mm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 19a. Informant's Name/Relationship (Type, Print Dauguer) item 2 ani 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3 21. Si vature Fureral Service Licens 22 Name and Address of Teneval Home, P. A. MD 21216 orth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ hemorrhage intracerebra disease or condition 24 12045 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed PROVED BY MEDICAL EX and Due to (or as a consequence of): signed by the attending physician d be detached for use as the buris CERTIFICATION Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 W No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertens ion Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending iniury 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1669764692 11/16/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Greene Hersh Balthmore 31. Date filed (Month, Day Year) 32. Regi Rrar's Signature State 3 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 28 2011 12:10 AM December Elizabeth Hamilton 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 108 Plantation Drive Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Davs Hours (Month, Day, Year) Feb. 4, 1919 Min. Mary Land 92 Director 220-28-3536 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 21740 U.S.A. 108 Plantation Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes Give 3 X Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Presser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fisher is marked or ပ Ida V. Marshall Nelson W. McGowan permit. Page 1 and 2 should the Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Plantation Drive, Hagerstown, Maryland 21740 Deloris L. Marshall/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State injury or Donation 5 Other (Specify) 01/03/2012 | Sharpsburg, Maryland Samples Manor Cem. of Funeral Service License 22. Name and Address of Facility Signature Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a consequence of): Examiner ORONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and s the burial-transit death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? jo Pregnant at time of death ed by the a detached f 1 Yes 2 L 9 Unknown 9 Unknown P.O. s been signed b Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 1 Yes 2 4 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed PERTEUSION certificate 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 🗌 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Graphing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier соmpleted within 2 To the I only one 29b. Signatu 29d. Date signed (Month, Day, Year)

□W - 5 State

Registrar

30. Name and address of

31. Date filed (Month, Day, Year)

(Item 23a) (Type, Print)

ACCHITORUN

mpleted cause of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ December 201^{rear} 2:28 \mathbf{P}^{M} John Perry Helm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Jan. 30, Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Director 120-40-1487 62 New York Jan. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 □ No Maryland | Montgomery Bethesda 10e. Street and Number ö 10f Zin Code 10g. Citizen of What Country? ital Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be r Funeral 5406 Cromwell Drive 20816 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian. Armed Forces?

1 Yes 2X No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Customs and Border College (1-4 or 5+) Elementary/Seconday (0-12) Protection Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental marked ဂ John Francis Helm Dorothy Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is 5406 Cromwell Drive, Bethesda, MD 20816 Susan Sutter Helm/Spouse other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2011 East Chester, NY Holy Mount Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee DeVol Funeral Home MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 lin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Intracranial hemorrhage Medical resulting in death) Due to (or as a consequence of): Examiner Brain herniation Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami and Due to (or as a consequence of): nding physician use as the burial /Medical certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy Physician/ 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 Cther (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Pulmonary embolism Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed Were autopsy findings available prior to completion of cause of Pancreatic cancer 24a. Was an page 2 s autopsy performe death? 2 🗌 No 2 **X** No 1 🗌 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes 2 🗌 No Other: မှ 1 🔀 Inpatient 2 🗌 ER/Outpatient_3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death

To the Funeral Director: After th 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

3 Division of Vital ohn Helm

> State Registrar

Medical

29a. Certifier (Check

only one) 29b. Signature a

MD, 8600 Old Georgetown Road, Bethesda, MD 20814 Sandra M. Delistathis, 31. Date filed (Month, Day, Year, 27 DEC

soulist attus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D59980

December 21, 2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 06-2011

State

Box 68760

P.O.

Chaitra S. Ujjani, M.D., 3800 Reservoir Road, Washington, DC 20007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year) DEC 29 2011

11-09727 Randolph Tirone H	State of Maryland / Bepartine	nt of Health and Mental Hyg	
Physician/	Registrar	te of Death	Reg. No. 2011 + J2 J Date of Death 3. Time of Death
Medical Examine	Randolph Tirone Haynes		Month Day Year 1042 hrs
	Aa. Facility Name (if not institution, give street and number) 4190 Houchen Place	4b. City, Town, or Location of Death Waldorf	4c. County of Death Charles
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthough 579-70-0457 1 M 2 F 58 Usual Residence of Decedent	Months Days Hours Min	Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign August 91,953 Country) DC
nd show any ncc.	MD Charles County Waldors		10d. Inside City Limits
the Maryland a or 28a-f show tified at once.	10e. Street and Number 4190 Houchen Place	10f. Zip Code 20602	10g. Citizen of What Country?
s after death with t iral", or items 23s niner must be not by Funeral I	11. Marital Status 1. Never Married 2 Married Armed Forces? 1 Yes 2 No 1 Widowed 4 Divorced If Yes, Give Yeer or Dates:	3. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric 1 Yes 2 No specify:	y Yes or No- 14. Race - American Indian, Black,
5-0036 ted within 72 hours: itgiene. other than "naturi the Medical Exami Completed to	45 December 1 5 1 6 10 15	cedent's Usual Occupation (Give kind of work ring most of working life. DO NOT use retired) .nister	done 16b. Kind of Business/Industry Self
21215-0036 vald be filed within 7 Mental Hygiene. marked other than it event, the Medical for the Medical for Be Comple	Symes Haynes Sr.	Katie E	
MD 21 od 2 should ulth and Me m 27 is ma aumatic cv	Randolph Tirone King- Son 81	3 Chesapeake St.S	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho isjury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1	2012 20c. Location - City or Town, State 6/ Suitland, MD 20019 ds St.NE WashingtonDC	
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or a july that hilliated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):		
0, i. be executed sician and surial - trans	UNPENDED AMENDED		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Ex	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 2 Unknown 2 Unkno	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year
, P.O. res that the signed by be detach	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, P.O. Box Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the arte completely filled in by the funeral director, page 2 should be deached for uedical Certification: To Be Completed by Physic			24a. Was an autopsy performed? 1 ✓ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 2 No
ician: scertifi rector,	25. Was case referred to medical examiner?	26.Place of Death (Check only atient 3 DOA Other Nursing Ho	one)
of V ig Phys ifter thi neral di	1 Yes 2 No Inpatient 2 ER/Outp 27. Manner of Death 28a, Date of Injury 28b Tim	e of Injury 28c. Injury at Work? 28d	ome 5 Residence 6 Other: Scene Describe how injury occurred
Division o poiral or Attending oous after death. noral Director. After filted in by the fune	1 Natural 5 Pending Po(Moth Day, Year) FOUNT Dec 27, 2011 1028 h	D: 1 Yes 2 ✓ No Sub	oject fell through attic floor of home
Divi Bipital or hours afte neral Dir filled in	3 Suicide 6 Could not be determined (Specify) Single Family Hor	ne 419	Location (Street and Number or Rural Route Number, City or Town, State) 0 Houchen Place, Waldorf, MD
To the Ho within 24 I to the Fu completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or inveand manner stated.	occurred at the time, date and place, and due stigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. time, date and place, and due to the cause(s)

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CONE

31. Data filed (Mosth, 2012ar)

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD Assistant Medical Evamination

State Registrar 32. Register's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 28, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Items 23aPtI,PtII,25,27,28a-f, per me, 1925,03/29/2012dhb
Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Symes Haynes Jr. ecembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata Medical -a (enter If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 5. Social Security Number 578-52-8328 SCountry) 1 X M 2 □ F Months Days Hours Min. 0372771940 Director Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director MD Charles County Waldorf 1X Yes 2 ☐ No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? items 23a Funeral 4190 Houchen Place 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2X No Specify: "natural" Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working National Institute life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) permit. Page 1 and 2 should be filed wift Department of Health and Mental Hygien Important: If item 27 is marked other tI any injury or other traumatic event, the once. Housekeeping Supervisor of Health Be 17. Father's Name (First, Middle, Last)
Symes Haynes Sr. 18. Mother's Name (First, Middle, Maiden Surname) Katie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Slaughter / Daughter 3338 Brothers Place SE Washington, DC 20032 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham Cem. 01/10/2011 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 20019 22, Name and Address of Facility Dunn&Sons 5635 Eads St.NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Hypothermia, Pehydration, Pneumonia and Interval Between Onset and Death Immediate Cause (Final hi Physician/ disease or condition resulting in death) Medical Acute Renal Failure Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (q as a consequence of FICATION APPROVED BY MEDICAL EXAMINER physician and the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day been signed by the should be detached 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has le 2 g autopsy r this certificate has eral director, page 2 perforn death? Hypertension 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 X Yes Hospital ဥ 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury **Fourist** *Day, Year)* **12/27/2011** Certificate: 27. Marmer of Death 28c. Injury at 28d. Describe how injury occurred

Disabled subject left un-Found: Natural 5 Pending 2 X Accident 1 ☐ Yes 2 👿 No attended after caregiver died 10:28 a.M neral Director: A Investigation 3 Suicide
4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 4190 Houchen Place, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home Waldorf,MD within 24 hours a

To the Funeral D

completed filled i Medical Çertifyirig Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/of investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner; the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOL ON State 0 Registrar

Please Type of Printing Black Indebible Ind. / Engure All Copies Are Legible. 1 - State Amend Items 23aPt1,11,23,27,28a-f per me,g925,03/29/2012dhb Registrar Certificate of Death Reg. No. Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ r 28<u>, 2011</u> James Louis Haynes December 16:00P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LaPlata Charles Medica (pnter If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 598=54-rit4973° **Funeral** Days Hours (Month, Day, Year) Country) 1 **X**M 2 □ F Director 578 = 54 = 4937
Usual Residence of Decedent 69 June 8,1942 DC 28a-f show 10c. City, Town or Location aţ 10a. State 10b. County 10d. Inside City Limits Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified MD Charles County Waldorf Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4190 Houchen Place 20602 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Black 3 🗆 Widowed 4 😿 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) 12th College (1-4 or 5+) United States Postal Postal Worker n and Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Symes Haynes Sr Katie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 915 Falcon Dr. Largo, Kevin J. Haynes/Son MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 01/06/2012 Suitland MD 20019 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn&Son 5635 Eads St.NE Washington, DC 23a. Part 1. Enter the disease, or complications that cause, the death. Do not enter the most of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each lift. Hypothermia. Dehydration. Malmitrit Approximate Interval Between Onset and Death Hypothermia, Dehydration, Malnutrition and Immediate Cause (Final VILLIA Physician/ disease or condition resulting in death) Medical Acute Renal Failure Due to (or Examiner incremental but exception a Examine if any, leading to immediate cause. Enter Underlying NED BY MEDICAL EXAMINER Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-tra inding physician use as the burial Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal deal ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year the a ed by the been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Dementia, Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an cate has I autopsy performed be Ea 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to Be 26. Pla e of Death (Check only one) examiner Hospital: Other: 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ this 28a. Date of injury **FOMM** *Day, Year)* **12/27/2011** n 24 hours after death.

Pe Funeral Director: After the pletely filled in by the funera 27 Mani r of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Disabled subject left un-Certificate; FOUND: 10:28 a 5 Pending work 1 \square XAccident 2**X** No Yes Investigation attended after caregiver died Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4190 Houchen Place, 4 Homicide determined Home Waldord,MD Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CM ON Date filed (Month, Day, Year, State JAN 0 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 3:47 December JOHN EARL HILL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 6. Sex 1 M 2 If Under 1 Year If Under . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Country) 0370171951 MD Director 60 219-52-1318 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 ☐ No Frederick Frederick MD 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21702 2002 Malvern Way , or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: "natural", Completed 3 Widowed 4 Divorced **Black** injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) education maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gladys Roberts Ambrose Hill 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Deborah Hill/wife 2002 Malvern Way, Frederick, MD 21702 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Frederick, MD 4 Donation 5 Other (Specify) 12/27/2011 Resthaven Mem. Gar. 21. Signature of Funeral Service Licenses Stauffer Funeral Homes, P.A. 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailing. List only one cause on each line. Approximate Interval Betwo Onset and De eval Between let and Death Assiration bnumonia Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Ileus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Yamurotic Kars neuroendocsine cancer the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year ed by the a detached f 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Liver Sailure 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown cate has been sig ; page 2 should b Completed mycordial . Were autopsy findings available prior to completion of cause of autopsy COPD performed?

Yes 2 No 1 ☐ Yes 2 ☐ No certificate No within 24 hours after death.

To the Funeral Director: After this certific: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 🗡 No Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 A Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Marius 7 80. Name and address of person who completed cause of death (Item 33a) (Type, Print)

State Registrar 31. Date filed (Month

Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2011 JOHN WILSON HARRIS JR December 12:14 A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 X M 2 | F Hours March Day, Virginia Director Yrs 223-23-3242 46 1965 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 126 West South Street 21701 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, las Decede... rmed Forces? □ Yes 2X No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ XNo Specify. 3 Widowed 4 Divorced Specify: Completed Black. 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Laborer Moving Company Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) 2 John Wilson Harris, Sr. Emma L. Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma L. Pearson - Mother 107 Pebble Brooks Lane, Winchester, VA 22602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

■ Burial 2

□ Cremation 3

□ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Mt. Pleasant Mem.ParkJan.4,2012 Aldie, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8914 Quarry Road Ames Funeral Home, Inc. Manassas, VA 20110 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has I ral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Tyes Other: 2 M'No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred After injury 1 X Natural 5 Pending ☐ Accident ☐ Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours are
To the Funeral Dir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 65183 27

Registrar

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31. Date filed (Month, Day, Year)

Liang

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ack

w 7th

Registrar's Signature

Frederick, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of Marylan		irtment of F tificate of E			20	11 43240			
	Decedent's Name (First, Middle, Last)					imouto or E	- Journ	2. Date of Dea	Reg. No. 2. Date of Death Month Day Year 3. Time of Death				
	Physicia Medic		Oliver	Solomon		Hansel		Decemb	<u>ember 31, 2011 8:00 F</u>				
	Examin	er	4a. Facility Name (if not institution, give str 1023 Frederick St				Location of Death nberland		4c. County o	Allegany			
	Funeral Director		210-10-3900	M 2 \square F 7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 06/19/	h (Year) (1918	9. Birthplace (State or Foreign Country) Maryland			
	and show	or	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	cation				10d. Inside City Limits			
	Maryla 28a-f	irect	MD Alleg	any		Cumberla	nd ———————			1 🕅 Yes 2 □ No			
	with the is 23a or nust be n	Funeral Director	10e. Street and Number 1023 Frederick S	treet		10f. Zip Code 2	1502		10g. Citizen of W	hat Country?			
39	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Thous marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 N Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ∰ Yes 2 ☐ No 19½ If Yes, Give Year or Dates. 19½	11_ 1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🙀 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, k, White, etc. White			
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212	within /giene. ner thai		Elementary/Seconday (0-12)	College (1-4 or 5+)		aborer			Sanitat	tion			
/land	d be filed Mental Hy arked oth rtic even	To Be	17. Father's Name (First, Middle, Last) Morgan	William	Hans	sel	18. Mother's Nam Annie	e (First, Middle,	Maiden Surname) Brode				
Mary 12 should aith and h 127 is ma		19a. Informant's Name/Relationship (Type Donald K. Hansel,				and Number or Rura Lane, Cor			ate, Zip Code) 21524				
Baltimore, Maryland 21215-0036	age 1 an ent of He nt: If iterr ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crem	sition (Name of natory or other place 's Cemete	:e)	Date 5/2012		City or Town, State			
Balti	permit. P Departm Importa any inju		21. Signan r of Funeral Service Licensee	nna			ur Street			ral Home, P.A. MD 21502			
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cause on each line.						Approximate Interval Between			
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Metastot Due to (or as a consequ		rcinor	na of	the	colon	- 28 months			
	Examiner	<u>_</u>	Sequentially list conditions, b										
	uted d ansit	Examiner	it any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Des to for as a consequ	iones orj.								
_	ate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequ	uence of):								
3760	ficate b g physi as the b	Jedical	d	-									
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Sc. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c	aldeath 3 🗌	Ectopic pregnand Other (specify)	ey .		23d. Date Mon	e of delivery hth Day Year			
. P.O.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.			bute to the cause of death? 3 □ Probably 4 🕅 Unknown			
ords	require been s should	Completed						24a. Was	an 24b. W	Vere autopsy findings available			
Rec	The law ate has page 2	Somp						autor perfo 1 Yes	rmed? d	rior to completion of cause of eath? Tes 2 No			
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Division of Vital Records,	ding Phys	ate: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injun	4 □ Nursing Ho y at		dence 6 COther				
ivisio	or Attendate deat Director: in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify			163 2 🗆 140		cation (Street and Number or Rural Route Number, or Town, State)				
Ω	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 Medical Examine	sian: To the best of my know er: On the basis of examination Practioner: To the best of m	n and/or invest	tigation, in my opinio	on, death occurred a	it the time, date a	and place, and due	to the cause(s) and manner stated.			
_	To the within To the compl	2	only one) 8 Certifying Nurse 29b. Signature and title of certifier	. I de	7/	29c. License	e number	oo, and due to th	29d. Date signed	(Month, Day, Year)			
	IVA.		30. Name and address of person who col	mpleted cause of death (Item	1 23a) (Tvpe. F	D002	3371		January —	y 3, 2012			
-	MAS		Qamar U. Zaman,	M.D., 12502	2 Willo		oad, Ste	440, Cu	umberland	d, MD 21502			
	Sta Registra		31. Date filed (Month, Day, Year) JAN 0 4 2012	32. Registrar's Signa	ture	Cal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1,324 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year MARIE PLACE HAVKINS DECEMBER 201: Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Yes Nov. 24, 6. Sex 9. Birthplace (State or Foreign **Funeral** Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days Hours 1 🗆 M 2 💢 F Maryland Director 217-82-2580 44 1967 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Howard Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 18045 Shaffers Mill Road 21771 U.S.A. Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumatic." 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ρ 1 Never Married 2 X Married 1 Yes 2 XNo Specify: If Yes, Give Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Society of Elementary/Seconday (0-12) Director of Administration Neurological Science Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Philip Place Carolyn Coker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,\,21771$ 19a. Informant's Name/Relationship (Type, Print) Ronald K. Hawkins - Husband 18045 Shaffers Mill Road, Mount Airy, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematorium 12/30/11 Alexandria, Virginia 21. Sign ture of Puneral Service bicense 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road. Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Probable Cardiores iratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Asystole Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to jor as a month in the off the attending physician and hed for use as the burial-transit Recurrent Lung Cancer resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 🔀 No been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician; The law page 2 has performe this certificate 1 Tes 2 No Yes 2 N 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify, Hospital မ 1 Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA n 24 hours after oeau... he Funeral Director: After th maleted filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 Gertifying Nurse Prantitioner To the best of my knowledge, death committed the time date and place, and due to the reuse(s) and manyer as stated 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 12/28/11 H0070973

DHMH 17 Rev 7/2009

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State Registrar Frederick, Md

21701

400 W 7th St

Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Margaret Daramola,

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Medember Day 2091 Oliver Austin Hott Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year} 1941 Months Days Min June 28, 1 ● M 2 □ F West Virginia Director 234-62-4455 70 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Frederick Monrovia 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 12209 Timber Run Court 21770 2 should be filed within remeath and Mental Hygiene.
27 is marked other than "natural", or items
77 is marked other than "natural" or items items ? 72 hours after death 12. Was Decedent Ever in U.S Was Decedo. Armed Forces? ✓ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ■ No Specify: Specify Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12College (1-4 or 5+) Meat Cutter Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ဂ္ဂ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. traumatic Marvin Hott Elva Catherine Landis Hot Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12209 Timber Run Court, Monrovia, MD 21770 Mrs. Virginia L. Hott, Wife altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan.3, 2012 Parklawn Mem. Park Rockville, Maryland al Service Mc Name and Address of Facility Molesworth-Williams, P.A., Funeral F 26401 Ridge Road, Damascus, MD 20872 23a. Part : Inter the disease, or complicat shock, or heart failure. List only one callimmediate Cause (Final he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death Physician/ netal disease or condition Medical resulting in death) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-transit dr as a consequence of): resulting in death) Last physician s the burial Physician/Medical certificate be Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Day Year Pregnant at time of death
Unknown detached 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar Margaret

400

32. Registrar's Signature

7th St

30. Name and address of person who completed cause of death (Item 2004 (Type, Print)

Davamola

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 43243 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ ORMA 1040 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severna Park 312 Canterbury Lane Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours 211-26-3823 79 **Director** 1 M 2 F Aug. 29,1932 Pennsylvania Yrs Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 312 Canterbury Lane 21146 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White "natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Screening Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ments Important: If item 27 is marked any injury or out. Reba Augusta Warner Charles Henry Sheaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Canterbury Lane Severna Park, MD 21146 Stephen D. Hayes / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 X Cremation 3 \square Removal from State emetery, crematory or other place Dec. Metro Crematory, INC Baltimore, MD 4 Donation 5 Other (Specify) 2011 22. Name and Address of Facility CREMATION DIRECT 495 Ritchie Hwy. 21. Signature of Funeral Service Licensee Severna Park, MD 21146 23a. Part 1. Enter the disease, e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Beath ANCREYAS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed Exam -trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural injury work? Accident
Suicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certified 29c. License number 0.243829ft. Pate signed (Month, Day, Year) ecember 217011 Name and address of person who completed cause of death (Item 23a) (Type, Print ANNAPOUS MON401 ENM MY HALDELENCE

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

DFC 2 7 2011

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 JEANNETTE RUTH HORNEY 1:30A December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Talbot Genesis Health Care-The Pines Easton If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🕱 F Days Hours Min Director 216-40-4079 MARYLAND Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at **Funeral Director OUEEN ANNE'S** CENTREVILLE 1 Yes 2 K No MD ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a USA 1460 GRANGE HALL ROAD 21617 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. ō Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) TRANSPORTATION SCHOOL BUS DRIVER Be event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev. 2 ANGELINE WEIGERT GARRETT WALTER RUTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1460 GRANGE HALL ROAD, CENTREVILLE, MD 21617 DAVID HORNEY/ HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION DEC. 28, STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, He 408 S. LIBERTY ST., CENTREVILLE, MD 21617 leufun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ YEARS disease or condition Medical resulting in death) Topacco Abuse / Aging Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Diabeles Hypertonsion Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Dabeles/ Hypervension Be Completed by Physician/Medical I • Hospital or Attending Physician. The law requires that the death certificate be a 24 hours after death.
• In Jours after death.
• Funeral Director. After this certificate has been signed by the attending physicis of Funeral Director. After this certificate has been signed by the cutending physicis as the Purit elect filled in by the funeral director, page 2 should be detached for use as the burnel. Arrenal Division of Vital Records, P.O. Box 68760 MAGETE IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cerebro VASCULCEY Acardan 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cardiomyopati 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performe 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accide 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho
To the Fune
completed fi 2 Under the cause of the cause (Check only one) 29b. Signature and title of certifier 20c License number 29d. Date signed (Month, Day, Year) areeu 12-27-201 S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUT CHMANG 610

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

282011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 20 4a. Facility Name (if not institution, give street and number) **Examiner** b. City, Town, or Location of Death 4c. County of Death ails oac 8. Date of Birth (Month, Day, **Funeral** Security Number 6. Sex If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 F Months Min. Director 1aryland Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No 10e. Street 10f. Zip Code 10g. Citizen of What Country? Funeral 11e Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Maryland 21215-0036 Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give 3 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) en Sle rro Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State Cambrida 4 Donation 5 Other (Specify) eneter 21. Signature of Funeral Service Licensee 22. Name and Address of acility
HENRY Funeral HOME, P.A any IENIRY SIA MD.2161 Washington Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Myocardia Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to or as a consequence of physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy been signed by the atte should be detached for Month Day Pregnant at time of death 5 Other (specify) Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical completed filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 Signature and title of cellif 29c. License number 29d. Date signed (Month, Day, Year) My

Registrar

State

Po

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marilyn Malott Higgins 1848P 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicamico Peninsula Regional medical center 8. Date of Birth (Month, Day, If Under Birthplace (State or Foreign Country) **Funeral** Months Min 214-32-1336 **Director** 81 1 🗆 M 2 🙀 F April 14,1930 Maryland Usual Residence of Deced 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Dorchester 1 X Yes 2 No Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 406 Commerce Street 21643 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō ģ Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 homemaker own home of Health and Should be filed w of Health and Mental Hygi If item 27 is marked other or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lloyd Albert Malott Eva Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other tra J. Ward Higgins husband 406 Commerce St., Hurlock, MD 21643 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 12/29/11 Delmar, DE 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran attending physician and Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital 1 🗌 Yes Other: မ 1 Unpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) eompletely filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. itle of certifier 29b. Signature and 29d, Date signed (Month, Day, Year) D70948 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CARROLL STREET, SALISBURY, MD 21801 NOUR. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ tARRIS Medical 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ISIX SYCAMOREST. Date of Birth (Month, Day, Ye If Unde 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 Months .Year Director should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD. 10e. Street and Number 10g. Citizen of What Country? by Funeral 1518 SYCAMORE 1.5.A Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: WhITE 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည ELTA MAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1518 SYCAMORE ST. BALTIMORE, MD. 21226 mportant: If item 27 DAVID 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition any injury or conce. Burial 2 ☐ Cremation 3 ☐ Removal from State 1-5-12 4 ☐ Donation 5 ☐ Other (Specify) CHENBURNIE, MD. GLENHANENMEMORIAL PK. 21. Signat@e of @r 22. Name and Address of Facility Muchery Funeral Home MOOGUZ 2601 MOUNTAIN RD PASADENA MD. 21122 23a. Part 1. Enter the disease, or conshock, or heart fail. List only hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Dyath End-stage Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conse u ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury CARDIO MY OPATHY that initiated events resulting in death) Last ing physician ar s as the burlal-t Physician/Medical UNCONTROLLES Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No Month Pregnant at time of death Day 23e. Did tobacco use contribute to the cause of death? Completed by PERIPHERAL VASCURAR 1 Yes 2 No 3 Probably 4 Onknown CHRONIC RESPIRATORY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? CAD 1 ☐ Yes 2 ☐ No 25. Was case referred to-medical of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify) ~2 🗹 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Mann of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 V Natural 5 Pending Division 2 🗌 No 1 🗌 Yes within 24 hours after death

To the Funeral Director: /
completed filled in by the f 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. who completed cause of death (Item 23a) (Type, Print) 1414 N. Crain Loy Suik 44 Glenburnit Greisman CANP

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra, MEND#23a(a)perMD12/27/11; RW, MCO Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 20. Helen Elizabeth 4:35 ам Johnsen Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring P.G. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 29 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2X 550-14-8589 Director 91 Sept. 1920 Usual Residence of Decedent sho 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3112 Gracefield Road, #423 20904 USA ural", or items ? Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Yes f Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis James Somers မ Aileen French 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole J. Price/Daughter 694 Alvarado Row, Stanford, CA 94305 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 0 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Department of Important: If any injury or Dec. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery $201\bar{1}$ Silver Spring, MD Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Failure Immediate Cause (Final Onset and Death Physician/ disease or condition Acute Kidney Injury Medical resulting in death) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed?
Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2**X** No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? Accident Investigation Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after within 24 hours a

To the Funeral C

completed filled poleted filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

DEC 27

30. Nama and address of person who completed cause of death (Item 23a) (Type Print)
Andrew Kundrat, MD 3110 Gracefield Road, Silver Spring, MD 20904

D36716

Dec.

20, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar 43249 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Lenore B. Jacobs 2011 7:40 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hebrew Home of Greater Washington **Rockville** 6. Sex Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 9-7-1922 Country) 1 🗆 M 2 🕱 F **Director** 182-18-4445 PA 89 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Completed by 1 ☐ Yes 2X No White Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Payro11 News Paper/ Fine China Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Gross Mary Bresofsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence R. Bachman - Son 9426 N. Pinefield Rd. Columbia MD 21045 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) any injury King David Mem Park | 12-27-2011 Bensalem, PA 21. Signature of Funeral Service Licensee Edward Sagel Funeral Direction 22. Name and Address of Facility 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Dementia disease or condition / Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner e attending physician and المرابعة as the burial-transit Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge death population and the firm of the cause (s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 mina farle 1212312011 D0064871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Montrose Rd Mina Fazli Rockville WD 20852 WD 6121 31. Date filed (Month, Day, Year) €2. Registrar's Sign ture State DEC 2 9 2011

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Please Type wpe or Print in Black Indelible, Ink. Ensure All Copies Are Legible.
MEND ITEM#5perFH, G923, 1/25/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 43250 Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / 25/1/1 Physician/ Charlie Jackson 03:08am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. **Funeral** 7. Age (In yrs, last birthday) 247-58-3037 8. Date of Birth 9. Birthplace (State or Foreign 03/27/36 Director 247-58-3087 Usual Residence of Dece 1 X M 2 | F South Carolina permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Md Prince George Hyattsville Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1207 Raydale Ct 20783 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces þ 1 Never Married 2 X Married 1 Yes 2 No 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Self-Employee 5th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elouise Benjamin Edward Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tawanta Whitmire Daughter 1222 Port Echo Lane Bowie, Md 20716 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 X Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 1/3/12 Glenwood 21. Signature of Funeral Service Licenses Shead Funeral Home & Cremation ٦ Georgia Ave NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final ARRYTHMIAS Onset and Death Physician/ disease or condition resulting in death) Medical ISCHEMIC STROKE Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Po in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 ∐ Yes ∠ ∟ 9 ☐ Unknown detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 100 3 Probably 4 Unknown should need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? V 2 400 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ပ 1 🗌 Yes 2 No Other: 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After after after in by the funeral birds. Natural 5 Pending ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 201 MAMUR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL TAKOMA LAGE ADVENTIST SHAMD SHAMIM, MD WASHINGTON 31. Date filed (Month, Day, Year) State

Registrar

9

MD-20012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lorraine Jackson 2011 РΜ 5:18 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 XXF 579-62-2507 63 Director Washington March DC Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified District of Columbia Washington 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3541 Jav Street. 20019 United States NE #101 iral", or items? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 ☒No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed 3 Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natur.
traumatic event, the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/ADisabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Jackson Myrtle Blanch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3541 Jay Street, NE #101 Washington, DC 20019 Willie Akins - Friend or other 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Dec 31, 2011 Glenwood Cemetery Washington, DC 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee Ruar 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respira shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Por Pregnant at time of death Day Month Year No page 2 should be detached the signed by contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 🗌 No 1 Yes Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 မ ER/Outpatient 3 DOA Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Douth Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes within 24 hours after death.

To the Funeral Director: A Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar

State

James

3001 Hospital Drive Cheverly, MD 20785

ne and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Catevenis,

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar				tificat					Reg. No.	00	Ц	4325	2
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsl George E. Crab		her						al Route Numbe ley, WV		Town, State	e, Zip Co	de)	
ge 1 an tof He :: If iten		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		te C	Place of Dispo cemetery, cren	natory or c	other plac			Date		ocation - Cit			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 2 tive Birth 2 Fetal death 5 Other (specify) 23d. Date of Month 23d. Date of Mo									ay Year				
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e Hosp 24 hou e Funei	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of Nurse Practitioner: To	f examinatio	n and/or invest	tigation, in	my opinio	on, death o	ccurred a	t the time, date a	and place	, and due to	the caus	e(s) and manner state	d.
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Stat Registra		31. Date filed (Month, Day, Year) JAN 0 3 201	2 A 32. Regis	trar's Signa	ture,	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Janet Lee James recember 24 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death at EAS Memoria Hospital astor 1 a If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) If Unde 8. Date of Birth (Month, Day, Year) **Funeral** Hours **Director** 216-40-4606 69 1 🗆 M 2 🔀 F March 22,1942 Maryland Usual Residence of Decedent items 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2104 Dailsville Road 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 2 1 Never Married 2 X Married Yes 2 X No 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) school bus contractor public school 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit Page 1 and 2 should be fi Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic ev once. Mildred Cannon John W. Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Goldsborough James Jr. husband 2104 Dailsville Road, Cambridge, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 👿 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) East New Market Cem. 12/28/11 East New Market, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) hromic Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Tes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28c. Injury at 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Month, Day, atural 2 Accident
3 Suicid 5 Pending work 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Carrifying Nurse Practitioper: To the Sest of my knowle Cat the fire 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item Ludwig J. Eg/seder III 503 Cynwood Drive, Easton, MD 21601 31. Date filed (Month, Day, Year, Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 21 per DVR G923 1/18/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar 43254 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 30 2011 ear 3:30 A M Curtis B. Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner Pikesville Envoy Health & Rehabilitation 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 66 212-44-1257 **Director** 1**X**□ M 2 □ F 5/18/1945 MD Usual Residence of Deceder or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits death with the Maryland Director MD Baltimore Pikesville 1 X Yes 2 No 10f. Zip Code ō 10e, Street and Number 10g. Citizen of What Country? ms 23a or USA 21208 Funeral 7 Sudbrook Lane items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CNA Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Surname)
Mildred Comegys Lewis Johnson ္ဝ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 Teakwood Dr., Apt. B2, Pikesville MD Carol Barrett/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Glen Burnie, MD 8/31/2011 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Maryland Cremation Services Signature of Funeral Service Licensee P O Box 1413 Baltimore MD 21203 Dorota Marshall per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 6 set and this Physician/ Small Cell Carcinoma to Lungs disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
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I Director: After this ed in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R088852 JANUARY 5 2012 CINI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kathleen Diamond, 2835 Smith Avenue, #203 Baltimore MD 21209 31. Date filed (Month, Day, Year) **31.** Date filed (Month, Day, Year) **31.** Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kauffman Margaret Kay DECEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** Hagerstown Washington Meritus Medical Center Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday 8. Date of Birth **Funeral** Min. Months Days Hours (Month, Day, Year 1 🗆 M 2 💢 F Director 201-34-7824 70 16, 1941 Pennsylvania Aug Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or than "natural", or items 23a the Medical Examiner must be Funeral U.S.A. 141 South Main Street 21713 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 2 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file Ith and Mental H 27 is marked of traumatic even မှ Margaret Steele Jesse Hoover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 sl Health a tem 27 i 17522 General Longstreet Circle Sharpsburg, MD 21782 Karen L. Gillespie/daughter Department of Healt Important: If item 2 any injury or other i Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Page 1 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 01/02/2011 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 23a. Part 1. shock, er the disease, or complication heart failure. List only one caus caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ach line. Approximate Interval Between Onset and Death Immediate/ Cause (Final Physician/ disease of condition Medical resulting in death) Due to (or as a consequence of) Examiner Shoc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy page 2 certificate Division of Vital funeral director, Be Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\subset}\) Nursing Home 5 \(\text{\subset}\) Residence 6 \(\text{\subset}\) Other (Specify) Hospital 2 No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending within 24 hours after death. To the Funeral Director: A Investigation completed filled in by the 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and addiess of person who completed cause of death (Item 23a) (Type, Print) phanis Rd Boomsboro M 2031) La 31. Date filed (Month, Ax Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:30 am Norman Kirk December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montaomeru Genesis Layhill Center Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🗓 M 2 🗆 Months Days Hours Min 09/09/193 Canada Yrs **Director** 548-56-8659 80 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 20906 U.S.A. 14204 Long Green Drive items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 0 ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗶 No Specify: "natural", Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Health Care Hospital Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Herman Kleiman Anne Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ian E. Kirk - Son 14204 Long Green Drive, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation ☐ other (Specify) Lincoln Crematory 12/27/2011 Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Ehter the disease, or complications that caused shock, of heart failure. List only one cause on each line Immediate Cause (Final Onset and Death *Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and s the burial transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ned by the a g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe | be a by Failure to Thrive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify, 1 Yes 2 X No မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After 5 Pending injury 1 X Natural death. Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

10

only one

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saadia Husain, M.D., 3227 Bel Pre Road, Silver Spring, Maryland 20906 31. Date filed (Month, Day, Year)

DEC 27 2011

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0064208

29d, Date signed (Month, Day, Year)

December 18. 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 21, 2011 6:30 aMAlice Rose Kaser Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Hillhaven Nursing Center, Inc. Adelphi 1 Year If Under Birthplace (State or Foreign Country) Social Security Number If Unde 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Months Hours 377-24-1212 **Director** 84 1 M 2 X F May 15, 1927 Michigan Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 Yes 2 X No P.G. Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6721 Raydale Road 20783 USA death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Examiner Black, White, etc. JO. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 . Page 1 and 2 should be filed within 72 hours after White 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Financial Assistant Accounting other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Zientarcki Rose Wojciechowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Florence Facchina/Sister 6721 Raydale Road, Hyattsville, MD 20783 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1XXBurial 2 Cremation 3XXRemoval from State JAN 2013, All Saints Cemetery Waterford, MI 4 Donation 5 Other (Specify) Signature of Funeral Service Licens France Is Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a Date T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between set and Death mins Immediate Cause (Final Physician/ Cardiac Arrhythmia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 20 yrs Coronary Artery Disease Securations let conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hyperlipidemia 30 yrs use as the burial that Cause (Disease or injury and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be dCardiomyopathy Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?

1 Yes 2 XNo
9 Unknown ξ Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Dementia, Osteoporosis, Hiatal Hernia, 1 Yes 2 No 3 Probably 4 No 11 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Diverticulosis 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has to the Funeral director, page 2 ? autopsy performed? Yes 2 K No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 10

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vivek Vaid, MD

31. Date filed (Month, Day, Year)

D17843

3311 Toledo Terrace, #B103, Hyattsville, MD 20782

Dec. 22, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ 2011 5:05 A December DONALD ARTHUR KELLY Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery 6315 Holland Meadow Lane Gaithersburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 1 🗙 M 2 🗆 F 137-30-8201 74 Yrs Oct. 5 1937 New York Usual Residence of Deced 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland notified at Director Bluffton 1 Yes 2 X No SC Beaufort 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number ö ms 23a or must be n Funeral United States 29909 9 Lynah Way items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status ral", or iter Examiner Armed Forces?

1 Syes 2 No Black, White, etc. 1955 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify If Yes, Give 1959 Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Communications Specialist Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, မ Evelyn Smith William Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29909 Carol J. Kelly / Wife 9 Lynah Way, Bluffton, South Carolina 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metropolitan Crem. 12/23/11 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee Ro 20882 P.O. Box 5038, Laytonsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Liver Cancer disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant g ☐ Unknown signed by the at d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Hemo Lipomatosis Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be director, page 2 s autopsy performed 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) director, Certificate: To Be Daughter Home examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending I Director: A Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Priystoan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainted as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20902 2101 Medical Center Drive, #200, Silver Spring, MD Kashif Firozvi, M.D. 31. Date filed (Month, Day, 32. Registrar's Signature State 201 arke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ KUYZ 0329 AM ecember Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** hester River hestertown 1-10801 tal If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Year) 1943 Washington, DC Days 1 🛛 M 2 🗆 F Months Hours Nov. 68 **Director** 213-42-6703 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🏝 No Maryland Kent Worton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21678 25549 Still Pond Neck Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 14. Bace - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify. 3 Widowed 4 N Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HVAC Electrician 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fishers is marked o 2 Cecilia Marie Overstreet Joseph F. Kurz, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth an Important: If item 27 is any injury or other trau Ijamsville, Maryland 21754 3397 Keats Court Joseph R. Kurz/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State December Lincoln Cemetery 29, 2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by failure Yes 2 □ No 3 □ Probably 4 □ Unknown or Attending Physician: The law requires Division of Vital Records, Rhab domplysis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 X No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 🛭 No Other: ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier P0069457

State Registrar DHMH 17 Rev 7/2009 Samantha Kalakurthy

29

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)
Samantha Kalakurthy, Chester Kiver Hospital, Chestertown: , MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year KENNEDY 9:55 AM LORENCE DEC 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month, Day, Ye 1 - M 2 - F Months Davs Hours **Director** 218-36-3779 87 Maryland Mar Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland at 10d. Inside City Limits Director must be notified MD Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21409 570 Bellerive Road APT # 127 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black 1 Yes 2 X No Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (UNK) life. DO NOT use retired) (UNK) Elementary/Seconday (0-12) College (1-4 or 5+) (UNK) Be 17. Father's Name (First, Middle, Last) (UNK) 18. Mother's Name (First, Middle, Maiden Surname) (UNK) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherrod Fairfax/Friend 4903 55th Place Hyattsville, MD 20781 Date 27, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 🗌 Removal from State Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 uneral Servi Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ METASTATIC disease or condition MONTHS Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Year Pregnant at time of death Day g Unknown 9 Unknown Division of Vital Records, P.O. p signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown as been signal 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed' death? 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work' n 24 hours after death.

ne Funeral Director: A
pleted filled in by the fu Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I

completed only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D63054 DECEMBER 23, 2011

State Registrar R gistrar's Signature

2007 TIDEWATER COLONY DR. #1A, ANNAPOLIS, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAJID CINA, MD,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend 20b per FH & 26 per DVR G923 1/23/12 dk State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month -30 pm **Physician** 2011 MA /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner 3995 AMERICAN CORNER KOAD CARDLINE tederals burg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 9. Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 7. Age (In yrs. lest birthday) 5. Social Security Number Funeral Months Days Hours Min 167-22-8718 85 Yrs. Director Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f ehov the Medical Examiner must be notified at FEDERALSBI 1 ☐ Yas 2 1 No CAROLINE by Funeral Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ò filed within 72 hours after death with 238 3995 Ambrican (21632 14 Bace - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status Black, White, atc. 1 Tas 2 No P45
If Yas, Giva
Year or Dates: 1 Never Married 2 Married ò Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 1946 Be Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) other than Elementery/Secondary (0-12) Collega (1-4or 5+) STEEL HEATTERMAN Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, I DRCE. 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Pages 1 and 2 should be 2DEVIT and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) MO21632 13995 AMBRICAN CORNER RUAD FEDERALSBURG BHILR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 MBurial 2 □ Cremation 3 □ Removal from State EASTERNSHORE VETS CEM. 1/5/2012 HURLOCK, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WILLIAMSON FUNDRAL HOME 21. Signature of Funeral Sarvice Licensee 311 S.MAINST. FEDERALSBURG, MO 21632 23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failura. List only one causa on each line. Approximata Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Wdv rsp.1601 Examiner Dua to (or es e consequence of): Examiner P 0 D YOU The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760. by Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown sate has been signated bage 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? edical Certification: To Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific complataly filled in by the tuneral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Spacify) residence Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 1 ☑ Natural 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 5 Pending investigation Injury 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida Hospital 1 Certifying Phyeician: To the best of my knowledga, daath occurred at the tima, data and placa, and dua to tha causa(s) and mannar as statad.

2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, daath occurred at the tima, data and placa, and dua to the causa(s) end mannar stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000713 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Browngal Are ms 21632

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day,

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h drals buy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 22, 2011 Christina Maria Lozupone 5:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday **Funeral** Months Davs Hours (Month, Day, Year) 218-66-8847 Director 1 M 2 18 F 59 May 27, 1952 Washington, DC Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 ☐ Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 20906 3511 Forest Edge Drive, Apt. USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 → No Specify. Specify Completed 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government File Clerk should be filed with and Mental Hygien Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank P. Lozupone Christine M. Kilbridge 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael F. Lozupone/Brother 18937 Cross Country Lane, Gaithersburg, MD 20879 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Dec. Silver Spring, MD 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc 500 University Blvd. W. Silver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Weeks om blications disease or condition Medical resulting in death) Due to (or as a onsequence of) Examiner Sequentially list conditions Examine Que to (or as a consequence of) If any, reading to immediate cause. Enter Underlying and and the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Month Dav Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Bipolar disease certificate has autopsy performed 2 No 1 Yes Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 P Other (Specify) 21 No 1 Tes ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft

completers filled in by the fu 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 00060634

Registrar

DHMH 17 Rev 06-2011

State

COLUMBIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6336

CEDAR

JOSEPH

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 December 6:55 A^M Stephen P. Leahy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 602A Main Street Gaithersburg Montgomery 8. Date of Birth (Month, Day, Year) Sept. 24,1960 Washington, DC 7. Age (in yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Funeral Days Hours Min. 1 🕅 M 2 🗆 F Months Director 212-78-3667 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 602A Main Street 20878 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married If Yes, Give 1 Yes 2 X No Specify White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Manager Warehouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Paul Leahy Jean Onofry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9603 Beman Woods Way, Potomac, MD 20854 Jean Raver/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, VA 4 Donation 5 Other (Specify) Metropolitan Crem. 12/22/2011 Signature of Funeral Service Licensee DeVol Funeral Home 22. Name and Address of Facility MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 luar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Leukodystrophy Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial trea Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ 1 Live Birth 2 Live Sirth 4 Pregnant at time of death Live Birth 2 Fetal death in the past 12 months? Month Day Year Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) Medical 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 December 21, 2011

State Registrar 31. Date filed (Month, Day, Year)

OFC 2 7 2011

32. Registrar's Signature

30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)

Coleman, MD,

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

1355 Piccard Drive, Rockville, MD 20850

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #9 per FH G923 1/24/12 dk
State of Maryland / Department of Health and Mental Hygiene 43265 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 12 рм Alice Lebowitz 2011 8:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Chesapeke Shores Nursing Home St. Mary's Lexington Park If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 7-14-1923 Hours Min. 1 □ M 2 💢 F Czechoslovakia Director 88 213-58-7904 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1X Yes 2 □ No MD St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21412 Great Mills Road 20653 United States death \ 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married \$ 1 ☐ Yes 2 💢 No If Yes, Give 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Bookkeeping Bookkeeper is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dvora Zabo Baruch Sternshus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Judith Marmer - Daughter Box 476 Mechanicsville, Maryland 20659 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MT. Lebanon Cemetery 12-23-2011 Adelphi, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Danzansky-Goldberg Magherhut MO1597 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): death certificate be executed Failure to Thrive Months and Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Dav Pregnant at time of death 2 💢 No the 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Advanced Dementia 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 \ No page this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 🔀 No Hospital Other: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After th 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pendina injury work? 1 ☐ Yes 2 ☐ No M Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie dress of person who completed cause of death (Item 23a) (Type, Print) mm Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Dorothy С. Logan December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Manor Care Wheaton 9. Birthplace (State or Foreign Country)
DC 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours Min Jan. IV. 1 M 2 X F 578-09-7201 95 Yrs **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County with the Maryland 10a. State 10c. City, Town or Location Director 1XXYes 2 No Wheaton Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō "natural", or items 23a or Funeral United States 20902 11901 Georgia Avenue death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Yes Baltimore, Maryland 21215-0036 within 72 hours after Specify: Black 1 ☐ Yes 2 A No Specify: If Yes, Give Completed 3 XWidowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Government Payrol1 Adjuster 12th æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed thent of Health and Mental H rtant: If item 27 is marked oth jury or other traumatic even ဂ Pauline Lee Samuel E. Wedge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4821 Illinois Avenue NW Washington, DC Pauline Wedge - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. Date 2. permit. Page 1 Department of Important: If it any injury or o 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Washington, DC Mt. 01ivet 21. Sign ture of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. Benning Road, NE Washington, DC 20019 ert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death years shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Acute Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** years <u>Atherosclerosis</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day 5 Other (specify) Pregnant at time of death the t 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Multiple Cerebrovascular Accidents 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Seizure Disorder s certificate has t lirector, page 2 s autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 2 🐴 No Hospital: ٥ 1 Inpatient 2 ER/Outpatient 3 DOA this ; After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred **X**Natural injury 5 \square Pending n 24 hours after death. Ie Funeral Director; Aft bleted filled in by the fur 2 🗆 No Accident
Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

8218 Wisconsin Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Albio1

Loreto S.

JAN 0 6 **201**2

Date filed (Month,

MD

32. Registr r's Sign

D31319

Bethesda, Maryland

January 4, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Miller Physician/ 6:15 M torrest Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrel Auilton Longianing ona contra If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, May 24, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 X M 2 □ F 1931 Maryland 80 Director 217-28-0521 Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Lonaconing Garrett 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7497 Avilton-Lonaconing Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 2 "natural", or 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental h Important: If item 27 is marked ott any injury or other transcence. ဂ Nellie Green Lloyd Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7497 Avilton-Lonaconing Rd., Lonaconing, MD 21539 Marie V. Miller/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Grantsville Cemetery | Dec. 30, 2011 4 ☐ Donation 5 ☐ Other (Specify) Grantsville, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): g physician and street burial-t Physician/Medical Box 68760 attending p for use as t IF FEMALE: Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death 1 Yes 2 L 9 Unknown ed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b I be deta þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page, performed' 2 🗆 No certificate **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f Location (Street and Number or Rural Route Number determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 69 Wolf State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar 43268 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Detc . 22 p2 011 Year $\overset{\text{3. Time of Death}}{5 \, \overset{\text{2. Time of Death}}{1.25}}_{\text{M}}$ Physician/ Μ Monterrosa Santos Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Temple Hills 3103 Good Hope Avenue #201 Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 48 Hours E Toun Salvador 578-15-8610 19/12/24/1963 Director 1 🗶 M 2 🗆 F or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Temple Hills MD 1 ☐ Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 20748 3103 Good Hope Avenue #201 El Salvador 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) EL Salvadoran 1 🕱 Yes 2 🗆 No Specify: 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Seferino Marquez Juana Monterrosa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl nt of Health a :: If item 27 is Maria A. Canenquez/Wife 3103 Good Hope Avenue Temple Hills, Md20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or c 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill 12/28/2011 Suitland, Maryland 4 Donation 5 Other (Specifi 21. Signatur PHILIPODS RENALDI FUNERAL SERVICE, P.A. o Funeral Service L Columbia Blvd.Silver Spring, Md20910 9241 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequent Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 - No ed by the a 1 | Yes 2 L 9 | Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy death? certificate | 2 X No 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗔 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After Completely filled in by the fun Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

29a. Certifier (Check only one)

29b. Signature and ti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

12500

Largo, Md. 20774

29d. Date signed (Month, Day, Year)

Dec.23,2011

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12, December 2011 11:00 AM Louis Miranda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Numbe Months Days Hours Min. Director 1 X M 2 🗆 F 212-15-3917 77 Nov. 25, 1934|Guatemala Usual Residence of Decede 28a-f show 10c. City, Town or Location the Maryland Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2X No Maryland | Montgomery Kensington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11002 Newport Mill Road 20895 United States death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. South 2 X No within 72 hours after Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: American "natural", Specify: Hispanic Completed 3 Widowed 4 N Divorced Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the government government worker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 401 Hungerford Drive, Rockville, Maryland 20850 Annise Chapmon- Custodian 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o once. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 1/06/2012 | Brentwood, Maryland 21. Signaturi o Funeral Service Licensee 22. Name and Address of Facility Simple Tribute MO1102 Kowe 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) days Medical Due to (or as a consequence of) Examiner Renal Failure days Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi). and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical death certificate be Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death the Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Hypertension, CVA, dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed een 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician; The law catchast; prior to completion of cause of death? perform Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 X No ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending М 1 Yes 2 No Accident the Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

hours after death. filled in by within 24 hours a

State

DEC 27 2011 Registrar

29b. Signature and title of certifier

Arun, Anuradha

31. Date filed (Month, Day, Year)

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wen My

🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0057630

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22,2011 Sidney Metzger 12:10p M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) **Director** 151-18-8073 1 🕱 M 2 🗆 F 94 New York 02/01/1917 Usual Residence of Decede 28a-f show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 🗌 Yes 2 🗶 No Silver Spring Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3148 Gracefield Road, #CL601 20904 u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Satellite and Mental Hygiene. is marked other than College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Electrical Engineer Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mollie Gottesman Julius Metzger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 9815 Hollow Glen Place, Silver Spring, MD 20910 Philip Metzger - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Grdns 12/23/2011 | Falls Church, Virginia 21. Signature of Funeral Sarvae Ucensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 210070 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heal dilure. List only one cause on each line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final Physician/ disease or condition resulting in death) Acute Myocardial Infarction Medical Due to (or as a consequence of) **Examiner** Conjective Heart Failure Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of y physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed <u>Severe Left Ventricle Dysfunction</u> Weeks that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year the g Unknown g Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛭 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Yes 2 🗶 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director. After 5 Pending 1 X Natural 1 🗌 Yes 2 🗌 No Accident Investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier юmpletely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

10

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Smitha Bhikkaji,

31. Date filed (Month, Day, Year)

D0064100

M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910

December 22, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygi	ene	10071
				ertificate of Death	T*	g. No. 2	432/1
	Physicia		1. Decedent's Name <i>(First, Middl</i> e, <i>Last)</i> James Michael Maguire		2. Date of Death	r 2 ⁰ 2, 2011	3. Time of Death 5:30 a M
بالبد	Medic Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
-	_Admi		9513 Montgomery Drive	Bethesda		Montgom	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 119–22–7662) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Bird	thplace (State or Foreign
	Director		Usual Residence of Decedent 1 ☑ 1 ☐ 91 Yrs.		Oct. 30,		node Island
	land show dat	ţo	10a, State 10b. County 10c. City, Town or L	ocation		-	10d. Inside City Limits
	Mary 28a-f otifie	irec	0 2	thesda			1 ☐ Yes 2 🛣 No
	ith the 3a or t be n	la D	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	ath w	Funeral Director	9513 Montgomery Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	USA 14. Race - Ame	rican Indian
0	ter de or ita	by F	1 Never Married 2 Married 1 Yes 2 No	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	Black, White	e, etc.
200	urs af tural" al Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates, 1943-46	1 ☐ Yes 2 🛣 No Specify:		Specify: Whi	ce
ر د ا	72 ho n "na Aedic	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king 1	6b. Kind of Business/	Industry
212	within giene.		Elementary/Secondary (U-12) College (1-4 or 5+)	Police Officer		Law En	forcement
Maryland 21215-0036	filed tal Hyg oth	о Ве	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma	iden Surname)	
<u> </u>	uld be I Meni narke natic	To	Patrick Maguire	Mary Du			
Ma	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			iling Address (Street and Number or Rui 13 Montgomery Driv			
saltimore,	1 and of Hea item		20a. Method of Disposition 20b. Place of Disp	position (Name of	Date 2	0c. Location - City or	
E	Page ment cant: It ant: It		1 🗷 Burial 2 □ Cremation 3 □ Removal from State demetery, credit 4 □ Donation 5 □ Other (Specify)	Heaven Cemetery	ec. 28, ₂₀₁₁ s	ilver Spri	ing, MD
Rail	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	? ਜੇਗਾਣ1ਾg Address ਦਿੱਠ ਜਾਂਖਿns 00 University Blvo	Funeral	Home Inc. 1ver Sprin	ng. MD 20901
T			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate
~	Ph _. sician/		Immediate Cause (Final disease or condition Urosepsis				Interval Between Onset and Death 2 days
	Medical Examiner		resulting in death) Due to (or as a consequence of):				
	10.00	Jer	Sequentially list conditions, if any, leading to immediate Urinary Tract Inf	ection			2 days
	per B	Examine	Cause (Disease or injury that initiated events c.	struction			2+ yrs
	e execuian an	al Ex	resulting in death) Last Due to (or as a consequence of):	1			10.
09/90	icate be executed physician and is the burial-trees	dical	Benign Prostate H				
00	rtific ing e as	w i	_ u	ypertrophy			10+ yrs
	es pu	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	
POX	death ce ne attend ed for us	sician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3 1 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	
O. BOX	at the death ce d by the attend letached for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)	22a Did toba	Month	ivery Day Year
s, P.O. Box	ires that the death ce signed by the attend Id be detached for us		23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3 1 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	ivery Day Year
ords, P.O. Box	w requires that the death ce sbeen signed by the attend should be detached for us		23b. Was decedent pregnant in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)	1 ☐ Yes	Month cco use contribute to 2 🌣 No 3 □ Pr 24b. Were aut	ivery Day Year the cause of death? obably 4 Unknown opsy findings available
records, P.O. Box	he law requires that the death ce te has been signed by the attend bage 2 should be detached for us		23b. Was decedent pregnant in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)	1 ☐ Yes 24a. Was an autopsy perform	Month cco use contribute to 2 № No 3 □ Pr 24b. Were aut prior to coded?	the cause of death? Tobably 4 Unknown Topsy findings available completion of cause of
tal Records, P.O. Box	cian: The law requires that the death ce ertificate has been signed by the attend ector, page 2 should be detached for us	Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify) underlying cause given in Part I.	1 Yes 24a. Was an autopsy perform 1 Yes 2	Month cco use contribute to 2 № No 3 □ Pr 24b. Were aut prior to coded?	ivery Day Year the cause of death? obably 4 Unknown opsy findings available
I VII al Records, P.O. Box	Physician: The law requires that the death ce this certificate has been signed by the attend al director, page 2 should be detached for us	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify) underlying cause given in Part I. 26. Place of Death (Checent 3 ☐ DOA Other:	1 ☐ Yes 24a. Was an autopsy perform 1 ☐ Yes 2 ck only one) ome 5 ☐ Residen	Month cco use contribute to 2 M No 3 Pr 24b. Were aut prior to c death? No 1 Yes cc 6 Other (Special	ivery Day Year the cause of death? robably 4 Unknown ropsy findings available completion of cause of
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DIVISION OF VITAL RECORDS, P.O. BOX	ne Hospital or Attending Physician: The law requires that the death oe in 24 hours after death. The Funeral Director: After this certificate has been signed by the attend pletely filled in by the funeral director, page 2 should be detached for us	Certificate; To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Cocurred at the time, date and place, a stigation, in my opinion, death occurred at stigation.	24a. Was an autopsy perform 1 Yes 2 ck only one) ome 5 Residen 28d. Describe how 28f. Location (Stre City or Town, and due to the causat the time, date and	Month cco use contribute to 2 No 3 Pr 24b. Were aut prior to c death? No 1 Yes cc 6 Other (Speci	ivery Day Year the cause of death? robably 4 □ Unknown ropsy findings available completion of cause of 2 □ No al Route Number, ated. rause(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Ascencio Magana Floriberto 81 50 M 105 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 45 473077966 Mexico none Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location Director 1 🗌 Yes 2 🛗 No Baltimore Baltimore MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21215 Funeral 4004 Clark Lane Mexico · death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. White 1 Never Married 2 Married 1 X Yes 2 □ No Specify. Mexican þ Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Landscape Laborer event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o 1 and 2 should be fill of Health and Mental fitem 27 is marked Magana Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. 2 Miguel Ascencio Ma. Olga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Way Apt.1B Reisterstown, Md21136 Ma.Olga Magana/Mother 20a. Method of Disposition 12/34/201 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Panteon Municipal 4 ☐ Donation 5 ☐ Other (Specify) PHIGIR AD RINALDI FUNERAL SERVICE, P.A. 241 Columbia Blvd. Silver Spring, Md20910 21. Signature of Funeral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirating arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Vear disease or condition Medical resulting in death) Due to (or as a consequence o **Examiner** Sequentially list conditions, Examine Due to (or as a consequence or): cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) ending physician a use as the burial-To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 T Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 2 🔀 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ၉ 1 🗌 Yes 2 X No 1 X Inpatient 2 DER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certi 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address

2 7 2011

DHMH 17 Rev 7/2009

ppleted cause of death (Item 23a) (Type, Print)

12

Baltimore, MD

Harkway

University

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State Registrar	Certificate of De		Reg. No.	1 43273
Physic Med		1. Decedent's Name <i>(First, Middle, Last)</i> John Edward McKee, Jr.		2. Date of D. Month	eath mber 26, Year 20	3. Time of Death 11 10:08 PM
Exam		4a. Facility Name (if not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Lo	ocation of Death	4c. County of Dea	
Funera Directo	_	5. Social Security Number 6. Sex 1×10^{-7} Age (in yrs. last b) 1×10^{-7} $1 $	oirthday) If Under 1 Year I	f Under 24 Hrs. 8. Date of Bi	irth 9. Bir	rthplace (State or Foreign
Maryland 28a-f show otified at	Funeral Director	Maryland Prince George's Belts	own or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
s 23a or	neral D	10e. Street and Number 4305 Birmingham Place	10f. Zip Code 20705	5	10g. Citizen of What Co	
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	13. Was Decedent of Hisp If Yes, specify Cuban, i	anic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) Specify:	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	6a. Decedent's Usual Occupatic (Give kind of work done dun life. DO NOT use retired) ISINESS Manager	ng most of working	16b. Kind of Business Plumbers La	
aryland 2: ould be filed wit nd Mental Hygie marked other imatic event, tt	To Be	17. Father's Name (First, Middle, Last) John Edward McKee, Sr.	11	8. Mother's Name (First, Middle Mary McCarthy		
md 2 should be ealth and Mer m 27 is marke ler traumatic			9b. Mailing Address (Street and 4305 Birminghan			
Baltimore, I bermit. Page 1 and 2 Department of Healt Important. If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	of Disposition (Name of htery, crematory or other place) politan Cremat	tory 12/31/2011	20c. Location - City or Alexandr:	Town, State ia, Virginia
Baltimo permit. Page Department c Important: If any injury or		21. Signature of Funeral Syrvice Ucensee	Bonaldowers	ofgwardt Funer Mill Road Bel	al Home, PA tsville, Ma	ryland 20705
Physici n Medica		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		such as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Examine		due to Mot	or Neuro	Disease		
outed nd	Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	·			
ificate be executed by sicial physician and as the burial transit	Aedical E	resulting in death) Last Due to (or as a consequence d	e of):			
the Hospital or Attending Physician: Title law requires that the death certificate be executed thin 24 hours after death. the Experiment of Attending Physician: Title law requires that the death certificate be executed thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and impleted filled in by the funeral director, page 2 should be detached for use as the burial transit.	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death			23d. Date of de Month	livery Day Year
uires that the signed by		Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given		d tobacco use contribute to the cause of death?	
The law red	Completed			24a. Was auto perfi	opsy prior to death?	topsy findings available completion of cause of
S certific	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/C	Other	of Death (Check only one)		
nding Phy ath. r: After this	Certificate: T		. Time of 28c. Injury at work?	4 Nursing Home 5 Resi 28d. Describe	how injury occurred	eny)
tal or Atte	I Certif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, f building, etc. (Specify)	farm, street, factory, office	28f. Location (City or Tou	Street and Number or Ru wn, State)	ral Route Number,
To the Hospital or Attending Physician: Tile within 24 hours after death. To the Funeral Director: After this certificate it completed filled in by the funeral director, page	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge only one) 3 Certifying Nurse Practioner: To the best of my knowledge	Vor investigation, in my opinion, c	death occurred at the time, date :	and place, and due to the	cause(s) and manner stated.
5		29b. Signature and title of certifier	29c. License nu	046952	29d. Date signed (Monti	h, Day, Year)
		Sukhjit Statu UMD Laurel	(Type, Print) 7300 l Regional Ho	lan Dusen R spital, Emer	d. Laur gency Der	lel, MD of. 20707
Sta Registr	re	31. Date filed (Month, Day, Year) DEC 2 9 2011 82. Registrar's Signature	hard.	1 ,	J / T	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Frances Η. Medical Minor December 201 2055 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Georges
rthplace (State or Foreign Prince Birthplace (State Country) **Funeral** 7. Age (In vrs. last birthdav) If Under 24 Hrs. If Under 8. Date of Birth (Month, Day, Year) Months Davs Hours 578-44-5589 **Director** 1 □ M 2 🔀 F Usual Residence of Decedent 75 May 17,1936 Wash., DC Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 609 Rock Creek Church Rd. 20010 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 K No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 X Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clothing Distributor Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Williams James Reatrice Brunson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3001 Charlie Court
Temple Hills, MD. 20748 Deborah Leftwich/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/9/12 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory Riverdale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, Examine Due to for sels consequence of, cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Month Day 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 100 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ANTOAMU 069737

5

Registrar
DHMH 17 Rev 06-2011

7503

SURRATTS ROAD

20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANIKOMMU, MP

UDHEER

JAN 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George E. MacVeigh 20, December 2011 5:15 PM Medical 4a. Facility Name (if not institution, give street and number) Center **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Buckingham's Choice Health Care Frederick Adamstown Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Dec 17, 1925 578-18-4223 86 Director XXM 2 I F Nebraska 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Frederick Adamstown 1 Yes 2XXNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a oi must be Funeral 7040 Upland Ridge Drive 21710 USA "natural", or items edical Examiner mu Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify. Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) al Hygiene.
ad other th Engineer NASA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever မ John G. MacVeigh Gertrude Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Ellen MacVeigh - Wife 7040 Upland Ridge Road, Adamstown, Maryland 21710 other 20a. Method of Disposition : of P : If it 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Gate of Heaven Cemetery 12/23/2011 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death h, sician/ disease or condition resulting in death) Metastatic prostate cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate

First Underlying

Cause (Disease or injury Due to (or as a consequence of) death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year the 9 Unknown 9 Unknown P.O. equires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hypertension Completed 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy abed death?
1 Yes performed? Yes 2x No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Health Care Center Hospital 2X No 1 🗆 Yes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending n 24 hours after use... ne Funeral Director: Af 1 🗌 Yes Accident 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🏅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2

To the I

comple 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D54143 D51643 12/22/11 10x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

Hiren N. Shah, M.D.

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31. Date filed (Month

32. Registrar's Signature

65C Thomas Johnson Drive, Frederick, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43276 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William McKenzie David Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany WMHS-RMC Cumberland 6. Sex 8. Date of Birth Birthplac Country) 7. Age (In vrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min Hours Mov 24, 1952 214-62-4494 Usual Residence of Deceden **Director** 1 🗙 M 2 🗆 F 59 28a-f show 10a. State 10c. City, Town or Location 10d, Inside City Limits the Maryland Director notified MD Allegany Cresaptown 1 XYes 2 No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or Funeral 14231 Elton Drive 21502 USA Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner muy or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 X Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Gee Bee Stores Dept. Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Sarah E. Dickev William G. McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell Fitzgerald 18610 Flanagan Lane MD 21557 Rawlings per. rep. Department of Health Important: If item 27 any injury or other trong once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Xremation cemetery, crematory or other place 3 Removal from State Scarpelli Funeral Home, P.A. 12/30/201 Cresaptown MD Donation 5 - Other Specify) 22. Name and Address of Eacility
Scarpelli Funeral Home, PA ignature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between UMONIA Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IE EEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No funeral director, page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 06-2011

State

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Name and address of per

Zaman

M.D. 12502 Willawbrook Rd. Ste. 440 Cumberland, MDave

who completed cause of death (Item 22) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 43277 State of Maryland / Department of Health and Mental Hygiene $2\,0\,1\,1$ For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 December 6:34 P M Allison Montgomery John Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's 29 Arthur Drive Ft. Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 219-12-3701 88 **Director** 1 **X** M 2 □ F 07/10/1923 Yrs Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County notified at Director 1 Yes 2 X XNo Prince George's Maryland Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 29 Arthur Drive 20744 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Vas Decedent 2 Volume Armed Forces?

K Yes 2 No 1943 Examiner Black, White, etc. ō 1 Never Married 2XXMarried þ If Yes, Give Year or Dates. 1 Yes 2XXNo Specify: White "natural" Completed 3 Widowed 4 Divorced 1976 other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Military U.S. Army 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည John Anthony Montgomery Lee Swann permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. Ana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sabra Jane Montgomery / Wife 29 Arthur Drive Ft. Washington, Maryland 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State 12/26/2011 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory Edgewater, Maryland of Funeral Service Ligensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Par : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ wrtic stenosus disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrilation 5 Spinal Stands S; 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed neurogenic bladdor 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No XX No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home **XX** Residence 6 Other (Specify) 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 Yes 2 No 28b. Time of 28d. Describe how injury occurred To the Funeral Director: After Completely filled in by the funeral 1XXNatural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) leted cause of death (Item 23a) (Type, Print) 9+1 WRUNNC, 8901 Wisconsinder, Betterda no 20889 State Registrar

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2 \, \cap$ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 3:10 PM 201 MISKO 1 3 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel . Social Security Number **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Min. 1 M 2 TXF 177-30-4409 75 1077371936 Country) **Director** Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Gambrills 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2266 Dairy Farm Road 21054 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Completed 3 → Widowed 4 □ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dental Care 12 <u>Receptionist</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Faber T. Brannan Rita M. Donaughe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Wilson Daughter 612 Knollwood Road Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 01/04/2012 Crownsville,MD 22. Name and Address of Facility 21. Signature of Fun Service Licenses 851 Annapolis Road Hardesty Funeral Home P.A.Gambrills, MD 21054 Jan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician DNasy disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a gone change of) attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live Fetal 30L.

Pregnant at time of death in the past 12 months? 1 ☐ Yes ∠ ₩ 9 ☐ Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No 1 ☐ Yes 2 🗷 No Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

the Hospital or Attending

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Annapolis, MD FARODA KHAWAJA 2001 ParkWAY Medica

64651

29d. Date signed (Month, Day, Year)

12, 27, 2011

Registrar

29b. Signature and title

atr

31. Date filed (Month, Day, Year) DEC 2 9 2011

Physician/Medical Certification: To

Completed by

Be

Medical

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		opicpregnancy ler (specify)	23d. Date of delivery Month Day Year			
	contributing to death but not resulting in the under		23e. Did tobacco use contribute to the cause of death?			
DEMENTIA RE	NAL INSUFFICIEN	4	1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown			
ANEMIA, EMF	HYSEMA, ANASAR	CA	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No			
25. Was case referred to medical examiner?	26. Place of Death (Check only one)					
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Hom	ne 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1 Anatural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	3d. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		factory, office 26	8f. Location (Street and Number or Rural Route Number, City or Town, State)			
	miner: On the best of my knowledge, death occ miner: On the basis of examination and/or investi and manner stated.		nd due to the cause(s) and manner as stated. It is a stated and place, and due to the cause(s)			
29b. Signature and title of confine		29c. License number	29d. Date signed (Month, Day, Year)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Reg. No.

4c. County of Death

10g Citizen of What Country?

USA

Own Home

Caroline

8:20 P M

9. Birthplace (State or Foreign

10d. inside City Limits

1 ☐Yes 2 X No

Alabama

14. Race - American Indian,

Black, White, etc.

Specify: White

16b. Kind of Business/Industry

20c. Location - City or Town, State

21631

Registrar

DHMH 17 Rev 1/2001

State

within 24 hours a

ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 0 0, 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 405 House Ea Ston 607 Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 D F Days (Month, Day, Mary land Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 P Yes 2 No Talbot Trappe 10g. Citizen of What Country? anderstown USA12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Ves 2 No 1942 Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Yes Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Ceith 1000 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 X Burial 2 X Cremation 3 L Removal from State 50 CEMP tery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility I HOME, P. A. Henry Funera MD.21613 Washington 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 4 eons Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cordio Vascely 1 Yes 2 No 3 Probably 4 Unknown hy Pertenson 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🔀 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 5 Pending injury 1 Natural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 24 hours after deat Funeral Director; completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 ECertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Muhammad

NFC 28 201

31. Date filed (Month, Day, Year)

Records,

of Vital

Division

Chesa Peake

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37. Registrar's Signature

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For Amend 4a per phys., Registrar DOR, 1/6/12, LDB

State of Maryland / Department of Health and Mental Hygiene

Certificate of Dooth

Registrar Name (Total Control N Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Omar Vignuelle Mills December 2011 6:15 Medical The Name of name of the street and number)

Chesapeake Woods Center 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Hours (Month, Day, Year) an. 2, 1923 Months Days Min 217-14-8693 88 Director Maryland Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Dorchester Church Creek 28a-f 1 Yes 2X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 2806 Lakesville Crapo Road 21622 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ŏ þ 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", Completed 3 Divorced 4 Divorced WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ral Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) waterman seafood permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, is Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H **7 is marked ot** ဂ McKinley Mills Florence Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Hayden daughter 1846 Charles Creek Rd., Church Creek, MD 21622 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland Veterans Cem, 12/29/11 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licensee 700 Locust St., Cambridge, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ athleroscierotic vascular disease disease or condition resulting in death) oyears Medical Due to (or as a consequence of) Examiner obstructive Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Investigation Could not be 1 \square Yes 2 🗌 No Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and addess of person who completed cause of death (Item 23a) (Type, Print) Patricia 100 Cambridge Johnson 31. Date filed (Month, Day, Year) istrar's Signature State 28

DHMH 17 Rev 7/2009

Registrar

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 30, 20ÏI 5:30 A M Amada Minor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bradford Oaks Nursing Home Prince George's Clinton Birthplace (State or Foreign Country) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 586-60-5689 **Director** 1 M 2XXF 79 03/10/1932 Philippines Usual Residence of Dece 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland notified at Director 1 Yes 2 XXX Prince George's Oxon Hill Maryland 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral USA 20745 1709 Fenwood Avenue Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō ģ 1 Never Married 2 X Married 1 ☐ Yes 2xxNo If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: "natural" 3 Widowed 4 Divorced Filipino Completed other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 4 years Technician Federal Government Payroll Be permit. Page 1 and 2 should be filed
Department of Health and Mental Hy
Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leocadia Magalong Sayson Roque 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1709 Fenwood Avenue Oxon Hill, Maryland 20745 Catalino Minor - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State KX Burial 2 Cremation 3 Removal for cemetery, crematory or other place, m State 01/04/2012 Resurrection Cem. Clinton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility of Funeral Salvice Licerisee George P. Kalas Funeral Home PA alas 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causi on each line. Approximate Interval Between Cardiovaralan Onset and Death Immediate Cause (Final Diseere Theroscleratio Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🔀 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes Yes 2 XN To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4XX Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at work? 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 045365

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL Sidanons, M.O. //)1/ 1170/ livings son Rd #101, ft washington MD 20146

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per FH G924 2/02/2012 JH State of Maryland / Department of Health and Mental Hygiene AMEND ITEM#19b, perFH , G924, 2/8/2012, WS Certificate of Death Reg. No. 2 For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ December Shirley L. Mangum 9:25A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Doctor's Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan . 2, Year) 940 Months Min 1 □ M 2 🔯 Days Director 71 Yrs Washington DC 5<u>78-52-2561</u> Usual Residence of Decedent show or 28a-f show 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Hyattsville 1 Yes 2X No 10e. Street and Number Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the <u>Medical Examiner must be n</u> 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4800 Cooper Lane 20784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify. 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) nengum, Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Josephine Simpson Floyd French, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3744 108th Lane, Buckeye, Arizona, 85396 Ronald E. Manqum/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 1/5/2012 Donation 5 Other (Specify) Metro Crematory Baltimore, Maryland e of Funeral Service License 22. Name and Address of Facility Signate Beall Funeral Home lx 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Breast disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō Month i signed by the air d be detached for 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an (24 hours after death. e Funeral Director: After this certificate has leted filled in by the funeral director, page 2 t autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 1 No Other: ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 ho

To the Fune

completed fi Gertifying Nurse Prantioner: To the best of my knowled, at the flow 5 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12-29-2011 END 70102 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good 20706 LANHAM MA ZAMA ROAN ULK 31. Date filed (Month, Pay Year) 3 2012 State Registrar

Amend #8 per AA Co. Health		lo									
A CO. nearui		For State	State o	f Marylar	•	artment of F rtificate of D		id Mental Hy	2	011	43284
		Registrar 1. Decedent's Name (First, Midd)	⊮ę, Last)		_		Jean	2. Date of D	Reg. No. C	. 0 1 1	3, Time of Death
Physicia Medic		Aud	rey	M	ad			Decem	ber 29.	2011	10:45 A ^M
Examin	er	4a. Facility Name (if not institutio	1			4b. City, Town, or		eath	4c. Cou	nty of Death	1 1
Funeral		Ginger Cove H 5. Social Security Number	6. Sex	7. Age (In yrs. i	ast birthday)	Annapo If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of Bi	rth 7/10/16	ne Arui	place /State or Foreign
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fand show	tor	10a. State 10b. Count	у	10c. Cit	ty, Town or Lo	cation	-				10d. Inside City Limits
e Mary r 28a-i notifie	Direc	Maryland Anne	Arundel			10f Zin Code	Annapo	olis	40.00	- (11/1) - 1 0	1 🗆 Yes 2 🔀 No
21215-0036 within 72 hours after death with the Maryland gigiene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Medical Examiner must be notified at	Funeral Director	4000 River Cre	escent Driv	e		10f. Zip Code	21	1401	10g. Citizen	USA	ntry ?
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Mary land 21215-0036 2 shoul : e filed within 72 hours after thith and scrital Hygiens 27 is marked other than "natural", or traume tic event, the Medical Exam	욘	Harold Lloyd						nleen Roc		*	
re, Maryla 1 and 2 shoule of f Health and en item 27 is merke other traumetin		19a. Informant's Name/Relations Susan M. Fitz		lallohtel	1	ng Address <i>(Street a</i>					
of Hez	-	20a. Method of Disposition 1 □ Burial 2 🛣 Cremation		20b. F	Place of Dispo	sition (Name of natory or other plac	- 1	Date		on - City or To	
Baltimore, I permit. Page 1 and 3 Department of Heatt Important: If item 2 any injury or other once.		4 Donation 5 Other	(Specify)	At]	lantic	Cremator	y 12	2/31/2011		Burnie	
Balt permit. Departi		21. Signature of Funeral Service	Licensee	0		2. Name and Addres		John M. '			al Home , MD 21401
		23a. Part 1. Enter the disease, of shock, or heart failure. List	or complications that conly one cause on each	aus of the deat							Approximate Interval Between
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68760 certificate be nding physici use as the bu	Š	F FEMALE:	23c. If yes, outo	come of pregna	incv						
Box death of the attented for us	Completed by Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 N	1 ☐ Live E 4 ☐ Pregr	Birth 2 Feta	aldeath 3	Ectopic pregnanc Other (specify)	у			Date of deliv Month	Day Year
P.O. E	Phys	g ☐ Unknown Part II. Other significant conditi	g Unkn		ulting in the u	inderlying care	en in Part I	22a Did	tabasas usa as	antributa ta t	he_cause of death?
S, P. inires that is signed Id be d	d by	Kaa	chul	ai	RUC	uj DI	Sea		Yes 2 N		bably 4 Unknown
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Re(5 8							perf	ormed?	death?	·
Vital nysician: nysician: director, l	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ NO	Hospital:	Inpatient 2 🗆	ED/Outpotion	Othe	er:	Check only the)	:d C 🗆 C	O4b /Oi6	
of ng Phy	ie:	27. Manner eath 1 atural 5 ☐ Pendi	28a. Date o		28b. Time of injury		at		how injury occ		7)
Division al or Attendin s after death. I Director: Aft ed in by the fur	<u>≅</u>	2 Accident Invest 3 Suicide 6 Could	tigation d not be	of Injuny - At he	ome farm stre		Yes 2 □ No	_	Street and Nur	mbor or Pum	il Route Number,
Divi	S	4 Homicide determ		ig, etc. (Specify		sot, factory, omoc			wn, State)	TIDEL OF FIGUR	rrioate Namber,
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Medical Certificate:	(Check 2 L Medical		s of examination	n and/or invest	tigation, in my opinio	n, death occuri	red at the time, date	and place, and	due to the ca	use(s) and manner stated.
To the within 2 To the comple		only one) 3 L Certifyin 29b. Signature and title of certifie	g Nurse Practioner: T	the best of m	y knowledge, d	death occurred at the 29c. License		d place, and due to t	he cause(s) and 29d. Date sig		
90) 'he	(V)	10	0	1000	518	9+	12-	<u>30.</u>	-2011
16		30. Name and address of person	legyra	bled	23a) (Type, F	Print)	tei	UD ET	Cert	Cele	ZW42
State Registra	e r	31. Date filed (Month, Day, Year) JAN 03	2012	egistrar's Signa	B. 4	ale					1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per me, 2923,01/13/2012dhb Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 1 201 ELIZABETH **GROVES** MONEY 3:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chester River Manor Chestertown Kent 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 K F Months Oct 14, 1918 Maryland 215-42-9236 Director 93 Usual Residence of Decedent items 23a or 28a-f show ler must be notified at 10a State death with the Maryland 10b County 10c. City, Town or Location Director 1 Yes 2 No Cecil Warwick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 735 Middle Neck Rd. 21912 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. or. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give should be filed within 72 hours after 3 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify "natural", 3 ₩ Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. other than " Elementary Elementary/Seconday (0-12) College (1-4 or 5+) 4 Elementary School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o မ Arthur A. Groves Mabel Cleaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Margaret Reese (daughter) P.O. Box 36 Kennedyville, MD. 21645 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 2 Cremation 3 Removal from State Chester Cemetery 12/16/11 4 ☐ Doration 5 ☐ other Specify Chestertown, MD 22. Name and Address of Facility Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 2 M00510 t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ erebsolasanlar disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). signed by the attending physician and I be detached for use as the burial-transit APPROVED BY ME that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATION Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Pregnant at time of death Year 2 No 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has autopsy Hospital or Attending Physician: The 1 Tyes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 X Yes 2 Other: ဂ္ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 Yes 2 X No Subject fell off sofa 04/25/2008 Investigation Unknown 24 hours after deat 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 735 Middle Neck Rd. Homicide determined Warwick, MD 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0051735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Delboy, M.D. 6602 Church Hill Rd. Chestertown, MD. 31. Date filed (Month, Day, Year) State JAN 1 3 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Jacqueline H. Miller 0446 A M 3812 20011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a BALTMORE 403 817AC AGNES 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number Funeral Months Davs Hours Min (Month, Day, Yea 10/7/1934 Country) Maryland 1 □ M 21⁄2 F 77 219-34-4546 Director Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10a. State 10b County 10d. Inside City Limits 10c. City. Town or Location death with the Maryland Director 1 Yes 2 XNo Baltimore Halethorpe MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4706 Aldgate Green 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō Completed by 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Dietary Aid Hospital Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4706 Aldgate Green, Halethorpe, Maryland 21227 Charles H. Miller/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) XBurial 2 Cremation 3 Removal from State Loudon Park Cemetery | 12/9/2011 Baltimore, Maryland Donation 5 Other (Specify) ture of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hemorrhia disease or condition resulting in death) hars Medical Due to (or as a consequent e of) Examiner nows troperitaries Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of, CERTIFICATION APPROVED BY NEOCOL EXAMINE Hospital or Attending Physician: The law requires that the death certificate be executed Coagulopathy associated with treatment for and that initiated events Atrial Fibrillation resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 ast IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year the detached signed by he cause of death? should be bably 4 \square Unknown this certificate has been psy findings available impletion of cause of

page မ after death.

Director: Aff
d in by the fur filled in by

25

CHINTAN

31. Date filed (Month, Day, Year)

PATEZ

1 ☐ Yes 2 █ No 9 ☐ Unknown	9 Unknown		
TERIPHERAL ARE	contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus		use contribute to th
		24a. Was an autopsy performed?	24b. Were autor prior to con death? No 1 Yes
Was case referred to medical	26. Place of Death (Check or	nly one)	
examiner?	Hospital: 1 Lippatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence	6 ☐ Other (Specify,

tificate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) in	jury M	work? 1 Yes 2 No	28d. Describe now injury occurred
Certif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, facto	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical	(Check 2 Medical Examine	r: On the basis of examination and/or	investigation,	n my opinion, death occurred	and due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) and manner stated ace, and due to the cause(s) and manner as stated.
	29b. Signature and title of certifier		2	gc. License number	29d. Date signed (Month, Day, Year)
	· Car	, Mi	0	926436	DECEMBER 6, 2011.
	30. Name and address of person who con	npleted cause of death (Item 23a) (T	ype, Print)		

BARTIMORETIMO

2 XNO

21229

State Registrar

24 hours Funeral I completed To the I

900 CATON

trar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 8:48 Рм Gordon Clyde McCusker December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hancock 3278 Get Away Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days 1 X M 2 □ F Hours 12 12 15 7 1 9 20 Director 9 1Yrs 212-24-6825 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No MD Washington Hancock 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21750 USA 3278 Get Away Lane items ; death v 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 X Never Married 2 Married 3altimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Saw Mill Logger Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucy Bishop Arlington McCusker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fish Hatchery RD Berkeley Springs, WV 25411 Belt, III/Godson <u>Francis L.</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State Smithsburg Crematory | 01/10/2012 | Smithsburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 M00260 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner disease Sequentially list conditions, rany, reading to infinite cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician; The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 5 Pending Investigation Could not be 1 ☐ Yes 2 ☐ No Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State

Medical

29a, Certifier

only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) 201 Z

Please Type or Print in Black Indelible Ink. Fyrsure/All Acroise Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | | 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER Day 2011 Physician/ **JERRY** RANDALL MOORE 10:04AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CHARLES WALDORF 11549 TIMBERBROOK DRIVE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 217-44-9743 Director 1 X M 2 🗆 F W. VIRGINIA MAR.4,1945 66 Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes XXNo CHARLES WALDORF MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 23a U. S. A. 20601 11549 TIMBERBROOK DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1x Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE "natural", 3 Divorced 4 Divorced Completed Year or Dates. VIETNAM the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U. S. GOVERNMENT PIPEFITTER 10 traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ! THELMA GENEVA MYERS မ ORVILLE WILLIAM MOORE .. Page 1 and 2 should be timent of Health and Mentant; If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11549 TIMBERBROOK DRIVE WALDORF, MD 20601 LINDA L. MOORE / SPOUSE other altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State DECEMBER Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State WALDORF, MARYLAND TRINITY MEM.GRDNS: 12,2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signature of Funeral Service Licenses 725 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARLIMOMA OF TONGUE Immediate Cause (Final SQUAMOS Physician/ disease or condition Medical resulting in death) Smoning **Examiner** Ciacarette 40 years Sequentially list conditions, ir any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-transit Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 Nursing Home 1 🗌 Inpatient 2 🗙 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Director: After 1 Natural 5 Pending work?
1 \sum Yes 2 \sum No Accident

Accident

Suicide

Homicide Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year P35345 con 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3261 OLD WASHINGTON RUAS WALDORF, MD 20602 WON 31. Date filed (Mont) Day, Year) State JAN 1 8 201 Registrar DHMH 17 Rev 06-2011

St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 43289 State of Maryland / Department of Health and Mental Hygiene 2 0 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nichols Carroll Leona 102th 28-2011 2:04p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Examiner Clear Spring Home Filmore If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth MD (215-14-2965 91 Director 1 □ M 2 🗶 F Usual Residence of Decedent show 10c. City, Town or Location Clear Spring 10a. State 10d. Inside City Limits must be notified at **Funeral Director** Washington 28a-f 1 Yes 2 X No 10f. Zip Code 21722 10e. Street and Number 13016 Spickler Road ō 10g. Citizen of What Country? 23a U.S.A. ral", or items ? Examiner mus . Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐Xlo If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify. "natural", Completed 3 XWidowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of MD Elementary/Secondary_(0-12) College (1-4 or 5+) 12th grade secretary Be 17. Father's Name (First, Middle, Last)
Garrett Clymer 18. Mother's Name (First, Middle, Maiden Surname) Mills Swandol ည Sallie Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 21711 12749 Pecktonville Rd. Big Pool, MD 21711 Susan Miller daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 12-30cemetery, crematory or other place)
Parkhead Cemetery 1 Veurial 2 Cremation 3 Removal from State Big Pool, MD 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 23a. Part 1. Enter the disease, precomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final SEMENTA ZEIMERS Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** ANEMIA 12 Sequentially list conditions. Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician the for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month. Pregnant at time of death 1 Yes 2 signed by the a d be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 15150R 37 1 Yes 2 No 3 Probably 4 Unknown page 2 should neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe the Hospital or Attending Physician: The I hin 24 hours after death. the Funeral Director, After this certificate h 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral in 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 0058181 hecember 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

JU-10

DHMH 17 Rev 06-2011

3248. ANTIETAM ST. #306 HAGERSTOWN MD

PEPRAH

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ .2011 1520 Joseph Newman becember Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton Prince Georges Southern Maryland Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** (Month, Day, Year) 577-60-8082 **Director 1X** M 2 □ F 20,1945 MD 66 April 28a-f show 10d. Inside City Limits Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No District Heights MD PG 10g. Citizen of What Country? 10f. Zip Code ò 10e. Street and Number items 23a Funeral United States 20747 2100 County Road #202 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò 1 Never Married 2 XMarried δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 KNo Specify. "natural", Completed 3 Widowed 4 Divorced Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private Fork Lift Operator other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorothy Proctor Joseph H. Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2100 County Road #202
District Heights, MD. 20747 Department of Health an Important. If item 27 is any injury or other Dianna Newman/wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1/9/12 cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory Riverdale, MD 22. Name and Address of Facility Hodges & Edwards F.H. e of Funeral-Service Licensee Suitland, MD. 20746 Silver Hill Rd., 3910 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami requires that the dearh certificate be executed and Due to (or as a consequence of resulting in death) Last artending physician a Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 9 Unknown signed by tl Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: Month, Day, Year) To the Hospital or Attending Natural Accident 5 Pending 1 Yes 2 No after death. Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and on investigation, in my spinion, add to determine the cause (s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) death (Item 23a) (Type, Print) ROAD. CLINTON 20735 MI 1503 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ Connie Nelson Elaine 1125 December 2011 Medical 4c. County of Death
Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cumberland Western MD Regional Medical Center 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 T 057257 1950 205-42-1907 Maryland 61 Director Usual Residence of Deceden or 28a-f show notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Allegany Cumberland 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n ö 10e. Street and Number Funeral 21502 USA 477 Baltimore Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status "natural", or iten edical Examiner r Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Marie permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic eve once. Whorton Roy Kifer, Jr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Valley View Lane, Frostburg, MD 21532 19a. Informant's Name/Relationship (Type, Print) Amie L. Nelson / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Qonation 5 □ Other (Specify) cemetery, crematory or other place) Artemas, PA 01/05/2012 Mt. Hope Cemetery Donation 5 Other (Specify) 22. Name and Address of Facility Alams Family Funeral flome, F.A. of Funeral Sa 21502 404 Decatur Street, Cumberland, MD Part 1 Serier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has performed? Yes 2 N certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No မ 1 🛛 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 4 hours after death.

*uneral Director: After the filled in by the funeral 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 31, 2011 D0054004 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Manth, Day, Year) 12

C. Khanna, M.D.,

32. Registrar's Signature

1221-E National Highway, LaVale, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 43292 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month 6. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** heste curity Number 6 Woods Cente If Unde 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) **Director** 1 X M 2 □ F 93 10-28a-f show 10a. State 10b. County important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No 10e. Street and Numbe 10g. Citizen of What Country? Funeral Was Decede... Armed Forces?... Ves 2 No 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 ▼Widowed 4 □ Divorced Whi 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. is marked other than College (1-4 or 5+) terma Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) conaiva 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 27-2011 Memorial 21. Signature of Funeral Service Licensee 308 High St. Cambridge MD 22. Name and Address of Facility leuxonb a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ardiovascular Physician/ disease or condition resulting in death) DUCEN Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed completely filled in by the funeral director, page 2 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at ' work? 1 ☐ Yes 28d. Describe how injury occurred injury 5 Pending 2 No 2 Accident Investigation 124 hours after deat e Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month. Dav. Year)

State Registrar

31. Date filed (Month, Day, Year) 2

atricia

hnson 100 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21215-0036

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Physician/ Η. Nickerson Jerome 6:23 A 2011 December Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year _ If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Hours Months 81 577-42-4023 Director 1 🛛 M 2 🗆 F July 19,1930 Massachusetts 28a-f show 10d. Inside City Limits 10c. City, Town or Location at 10a State the Maryland Director sms 23a or 28a-f sh r must be notified a Severna Park MD Anne Arundel 1 ☐ Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21146 600 W. McKinsey Road, Apt. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S ıral", or iten I Examiner ı Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1954 1 Never Married 2 X Married Completed by . Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examitury or other traumatic event, the Medical Examit Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: 1961 Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Beer Distributor Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Ruth Dunderdale Oliver E. Nickerson 19a. Informant's Name/Relationship (Type, Print) Step-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Westervelt / Arnold, MD 21012 1240 Ashby Court Daughter Date 03, 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Jan. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o Important: If any injury or once. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. 2012 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licenses 23a. Pand. Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1) EMENTA 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy page 2 perforn GONET DISGASE 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical To Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work?
1 Yes 2 No Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural Accident 5 \square Pending s after death.

I Director: After the full of the full Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 80

State Registrar

10+1

116

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Morningth.

Phys Me Exa Fune Direc permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 15 is marked other than "natural", or items 23a or 28a-1 show ann initror or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 Physicia Medi Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 26

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_	-	Registrar 1. Decedent's Name	e (First, Middle,	Last)			eruncai	eor	Jealii		2. Date of De	Reg. N	lo. 💪 (<i>J</i> 1	3. Time of Death
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Director		578-86-7		1 X] M 2 □ F	40	O Yrs. Months Days			Hours Min. (Month, Day Jan. 2						olumbia
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28a-f	Director	MD	Anne A	rundel	A	rnol	db								1 ☐ Yes 2X No
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is ma		19a. Informant's Na									l Route Numbe				Code)
Health em 27 ther to		Mary Naylor / Wife 628 Bay Green Drive Arnold, MD 21012 20a. Method of Disposition Date 20b. Place of Disposition (Name of Date 20c. Location - City or Town											Town State		
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Department of Health and Mental Hygiene. Important: If item 27a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu			icare		22. Name a	nd Addre	ss of Facilit	ty D	Δ Sev	ærn	a Pa	rk Fi	neral Home
Q = # 9	21. Signature of Funoret Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park 1 495 Ritchie Hwy, Severna Park, 23a. Part 1 Enter 15 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line.											rk, ì	21146		
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death. :tor: Al / the fu	Certificate:	2 Accident 3 Suicide	Investig 6 Could r	ation ot be	of Injury - At ho	mo form	M M	1 🗆	Yes 2 🗆	-	Opt Leasting /	Ctracto	m ed Als con h	or or Dum	al Pouto Number
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omplet	Me		Certifying	Nurse Practitioner	: To the best of r	ny knowle	dge, death oo	curred at t	the time, dat	ite and pla	ce, and due to	the caus	se(s) and	manner as	stated.
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26		30. Name and addr	ess of person v	ho completed caus	se of death (Item	23a) (Typ	e, Print)	edic	al Pn	uka	ian F	- un	ra on	is.	na.
Stat	е	31. Date filed (Mont		3 2012 32. R	e istrar's Signa	ture &	1	1	-11 10	VALCO		1 319	- ~ - 0	1 1 1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 1 1

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-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	at birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		9. Birthplac	ce (State or Foreign
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	is filed within 72 hours after death with the Manyland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11806 Greensboro Rd.			21639			USA		
	death r item iner n		11. Marital Status	/as Decedent Ever in U.S. rmed Forces? ★ Yes 2 □ No	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - American ck, White, etc	
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lan	be fill lental rked c	2	Francis Lee Owen				Ruth A	nn Thoma	s Felic	iano	
Maryland	of and 2 should be file of Health and Mental Filem 27 is marked or rother traumatic ever		19a. Informant's Name/Relationship (Type, Pr	int)		g Address (Street a			-		
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Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		1 XBurial 2 ☐ Cremation 3 ☐ Remo	oval from State cer	metery, cren	sition (Name of natory or other place		Date		-	
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-	cate be executed physician and s the burial-transit	dical E	resulting in death) Last	Due to (or as a conseque	ence ot):		CERTIFICATION APP	Nov		- 1	
760	that the death certificate be executed ned by the attending physician and e detached for use as the burial-transi	ledic	d								
89 >	eath certifica attending pl	an/N	23b. was decedent pregnant	yes, outcome of pregnan-		Ectopic pregnanc	V			ate of delivery	
Box 687	death he att	Physician/Me	in the past 12 months?	Pregnant at time of de Unknown		Other (specify)			M	onth D	ay Year
P.O.	hat the dea ed by the a detached f	, Ph	Part II. Other significant conditions contribu	iting to death but not resu	Iting in the u	nderlying cause giv	ren in Part I.	23e. Did t	obacco use	tribute to the	cause of death?
	v requires that is been signed to should be det	d by						1 🗆	Yes 2 No	3 🗌 Proba	bly 4 🗆 Unknown
ord	v requ	olete						24a. Was	an / 24b	. Were autops	y findings available pletion of cause of
Rec	Physician: The law requires this certificate has been signal director, page 2 should by	Completed						nerfo	ormed? 2 No	death?	
tall	ysician: The is certificate director, pag	Be	25. Was case referred to predical examiner?	tal:		26. Pla	ace of Death (Chec				
of Vital Records,	Physi this c	2:	1 X Yes 2 19 No	1 Inpatient 2 L E	R/Outpatier 28b. Time of	t 3 🗆 DOA	4 ☐ Nursing H	lome 5 Resident	dence 6 Ot		
o u	Attending I ar death. ector: After by the funer	icate	1 Matural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work		Edd. Bodonisa			
Division	I or Attendi after death. Director: A d in by the fu	Certificate:	3 Suicide 6 Could not be	Be. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S	Street and Num.	ber or Rural R	oute Number,
Ö	oital or urs afte ral Dir									anor en atator	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: Conly one) 3 Certifying Nurse Pra	in the basis of examination	and/or inves	tigation, in my opinic	n. death occurred	at the time, date a	and place, and d	ue to the caus	e(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifier		, in strenge	29c. License	number		29d. Date sign	ed (Month, Da	ay, Year)
			1tal St	1	N+O	RES	5-000)	Decen	nbera	29 2011
			30. Name and address of person who comple	11	23a) (Type, F	Print)	> A1	-16- IL	Ba 11-	00	29 2011 Morium
	Sta	te.	31. Date filed (Month, Day, Year)	32. Aegistrar's Signatu	ure	0000	10, 10	offe 1th	PULIT	inorg	MINCIPI
	Registr		JAN 0 4 2012	finana p	1.	ever					

Caroline

far to ME

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onnie Dale Po		State of Maryland / Department of 1- For State Registrar Certificate of		Reg. No.	011 43298			
Physicia Medical Exami		Bonnie Bale 101tel		Date of Death Month Day Yea December 31, 2011	3. Time of Death 0815 hrs			
		Chester River Hospital	b. City, Town, or Location of Death Chester River	Kent				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 261-91-5090 1 M 2 X F 48 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min	•	Foreign			
nd ibow any ice,	<u> </u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Caroline Goldsbor			10d. Inside City Limits 1 Yes 2 X No			
ath with the Maryland items 23a or 28a-f abow ast be notified at once.	Director	10e. Street and Number 23865 Bridgetown Road	10f. Zip Code 21636	10g. Citizen of Wh				
P 10	y Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was If Ye 1 Yes 2 No	Decedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto Yes 2 X No specify:	pecify Yes or No- 14. Race	- American Indian, Black,			
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after to of Health and Mental Hygiene. It: If item 27 is marked other than "natural", after traumatic event, the Medical Examines.	ompleted by		's Usual Occupation (Give kind of v st of working life. DO NOT use reti		siness/Industry			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	17. Father's Name (First, Middle, Last) Richard Turner	18.Motner's Name Joyce E Address (Street and Number or F					
e, MD 2 1 and 2 shoul Health and IN item 27 is m	To	James R. Porter, III/ husband 23865 20a. Method of Disposition 20b. Place of Disposit	5 Bridgetown Roa	d; Goldsboro, M	, ,			
Baltimore, MD 2 pemit. Pages I and 2 shoul Department of Health and N Important: If item 27 is m injury nr nither traumatic.		4 Donation 5 Other Specify: Arlington 21. Signature of Funeral Service Licensee 22. Na	National Cm Feb	Box 160; Green	sboro, MD			
Physician <th colspan="8">Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart</th>	Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart							
ceuted and - transit	Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):						
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and applietely filled in by the funeral director, page 2 should be detached for use as the burial - transil.	Physician/Medical	past 12 months? 4 Pregnant at time of death 5 Other	r me, g923 1-24-1 al death 3 Ectopic pregna	23d. Date of o	delivery Day Year			
, P.O. Borres that the dearing signed by the a be detached for	à	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco use contrib	oute to the cause of death?			
of Vital Records, ig Physician: The law require the this certificate has been sineral director, page 2 should be	Completed			autopsy pr perform <u>ed</u> ? de	/ere autopsy findings available ior to completion of cause of eath? Yes 2 No			
of Vital Recing Physician: The After this certificate uneral director, page	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	ury 28c. Injury at Work?	g Home 5 Residence 6 28d. Describe how injury occurre				
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f	Certification	Natural 2 X Accident 3 Suicide 4 Homicide Pending Investigation Could not be determined 1 Could not be determined Specify Residence	am , factory, office building, etc.	subject ingested 28f. Location (Street and Number or Town, State) 23865 Goldsboro, MD.				
To the Hosp within 24 hos To the Fune completely fi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurre and manner stated.	ed at the time, date and place, and on, in my opinion, death occurred a	due to the cause(s) and manner of the time, date and place, and du	e to the cause(s)			
<i>h</i>	ž	29b. Signature and title of certifier. 30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	29d. Date signed January 1, 2	d (Month, Day, Year) 2012			
Q St.	ate	Victor Weedn MD JD Assistant Medical Examiner 900 W.	Baltimore Street, Baltimore	re, MD 21223				
Regist	rar	31. Date filed Worth Dany 2012 32. Registrar's Signature from						

OCME

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 900 W. Baltimore Street, Baltimore, MD 21223

Donna M. Vincenti, MD

192012

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43298 For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12^{Mo}/20/2011 Day Physician/ Heleme Maria Pacchione 6:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anchorage Nursing and Rehab Salisbury Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 Months Days Hours Min 166-09-4832 0370677914 Director PA Usual Residence of Decedent 28a-f show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location Berlin 10d. Inside City Limits Director Worcester MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2181 28 Lookaut Point USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specif White If Yes, Give Year or Dates "natural", 3XXWidowed 4 ☐ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) House Wife Own Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vincent Defrancesco Philamenea Campana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Pacchione/ Son 28 Lookout Point Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Med Cure Inc. 12/26/2011 Cumberland, RI 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potarac Street Hagerstown, MD 21740 M01613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ere beo Vascular disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician at the burial Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Dav Year Pregnant at time of death the 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Hospital or Attending Physician: The I 24 hours after death.
Funeral Director: After this certificate heted filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 🔀 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4XX Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1XX Natural 5 Pending 1 Yes 2 No Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signatu 29c. License number mer MD D 0071972 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 S. DIVISION STREET TW-Z SAMEER SHAIK ABDUL SALISBURY, MD-21804. State Registrar

DHMH 17 Rev 7/2009

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12-20 ay 11 Physician/ 12:30p м Iris C. Phillips Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Sligo Creek Center Montgomery Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthdav **Funeral** 1 □ M 2**X** F Days Hours Months 8-24-1 922 89 215-62-5501 **Director** Guyana Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at with the Maryland Director 1 X Yes 2 No Maryland Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? Funeral 23a United States Apartment 214 20783 6305 Riggs Road, Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 9 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Yes, Give Specify: Black "natural", Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Certified Nursing Assistant Health of Health and Mental Hygie If item 27 is marked other r other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ Rebecca Smith Leonard David 19a. Informant's Name/Relationship (Type, Print) Constance G. Thompson/ Granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3909 Nicholson Street, Hyattsville, Maryland 20782 Department of Healt Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition National Harmony Memorial Park ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-28-2011 Landover, Maryland 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, North West Washington, District of Columbia 20012 Signator of Funeral Service Lie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final theres devotic Cardiovasa Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Ta that initiated events Due to (or as a consequence of): resulting in death) Last anding physician a use as the burial-Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? ģ Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a Yes 2 X No 9 Unknown 1 ☐ Yes ∠ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed Yes 2 X No 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🔀 No Other: 4 🛮 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes 2 🗀 No 28d. Describe how injury occurred Certificate: 1 🔀 Natural injury 5 Pending within 24 hours after death. To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 👿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpleted 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0060100 December 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University Boulevard East, Suite 27 Silver Spring, MD 20903 Ahmed 831 Tahmina K.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 7 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 43300 State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#25perMD, 12/27/11; EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pattie B. Perry Day 11:30 PM 2071 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4712 Quadrant St Capitol Heights Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 1 □ M 2 🏋 F 579-30-3018 99 05-26-1912 Usual Residence of Decedent C. N. 28a-f show aţ 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits notified 1 ✓ Yes 2 ☐ No Prince Georges Capitol Hgts 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 4712 Quadrant Street 20743 U.S. items ? Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, r than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify. 3

Widowed 4 □ Divorced Completed Specify: black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) self employed of Health and Mental Hygiene.
If item 27 is marked other tha 12th grade seamstress/tailor Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Richardson Mollie Lynch 19a. Informant's Name/Relationship (Type, Printson . & daughter in Cleo and Marcella Perry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4712 Quadrant Str, Capitol Hgts, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 6 Department o Important: If any injury or Suitland, Maryland 12/21/11 Lincoln Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BACON Funeral Home acon Str. NW. Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s Approximate
Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CARDIO RESPIRATORY disease or condition resulting in death) Medical Examiner HOULT PATILLER Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ADVANCED ACZHEIMER'S that initiated events resulting in death) Last physiciar s the buri buri Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year 1 Yes 2 p the a Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate Yes 2 Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 X No Other: မှု 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred + Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and litle of certifier no HES MD038754 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar

State

1160

Varnum

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 3:50 A December Mitchell PAUL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Towson Gilchrist Hospice 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours (Month, Day, Year) **Director** 216-45-3378 1 **X** M 2 □ F 62 Feb. 23, 1949 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director Pikesville 1 🗆 Yes 2 🔀 No 28a-f Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral United States 4500 Coffee Tree Court 21208 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 white If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Contract Law 5+ Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Department of Health and Menta Important: If item 27 is marked any injury or other traumatic conce. ပ Rose Lechter William Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4500 Coffee Tree Ct., Pikesville, MD 21208 Lisa Paul, Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 № Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Judean Memorial Gardens 12/27/11 Olney, MD Donation 5 Dther (Specify) Torchinsky Hebrew Funeral Home 254 Carroll St. NW. Washington, DC 20012 23a. Part — Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ conces disease or condition resulting in death) DRASTAGE LLVS Medical Die to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of, n and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 autopsy performed? Yes 2 N within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Hother (Specify) WSDICE 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 10 December 25 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles HANVES MO6701

State Registrar 31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra MEND#28a+bperMD, 12/27/11; BMW, Moto Certificate of Death 43302 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 20, 2011 12:05 p M Soon Park Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9527 Haddaway Place Laurel Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 212-98-7481 1 □ M 2 🏻 F 74 Yrs. Nov. 21, 1937 Usual Residence of Decedent Korea or items 23a or 28a-f show 10c. City, Town or Location filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2x No MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9527 Haddaway Place 20723 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc.
Asian þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. life. DO NOT use retir Homemaker Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hv.
Important: If item 27 is markany injury or other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sung S. Yo Myung S. Choi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Park/Daughter 5423 <u>Alta Vista Road, Bethesda. MD 20814</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Dec. 2 2011 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W. Silver Spring MD_20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ Lung Canca 31WS disease or condition Medical resulting in death) Due to fer as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) the attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year Dav Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 🗶 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No 12:051 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director.

> State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifier Christin

Han 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D60372

St. CRB2, Rm 553 Bahmon, MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 43303 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:20 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15253 Callaway Court Glenwood Howard Social Security Number If Under If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Days 282-07-3076 Director 1 🗆 M 2 🕱 F 95 01/03/1916 Ohio Usual Residence of Decedent 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Howard Glenwood 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 15253 Callaway Court 21738 u.s.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö ģ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify 'natural", 3 X Widowed 4 Divorced Specify. Completed Caucasian Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. the Travel Coordinator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lukas Bazan Susanna Gaca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Denise Carol Eden - Daughter 15253 Callaway Court, Glenwood, Maryland 21738 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/31/2011 | Silver Spring, Maryland Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 'n 2 Up <u>11800 New Hampshire Ave., Silver Spring, MD 20904</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician disease or condition ifars Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (s a consequence of resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 1 Yes 2 No 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home nours after death.

neral Director: After this y filled in by the funeral di 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral E

Completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 28 2011 Cheey Dugan Buck Leonardi, M.D. 30. Name and address of person ed cause of death (Item 23a) (Type, Print) 480 Dorsey

State

Registrar

31. Date filed (Month, Day, Year

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43304 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elia Sanchez Parsons <u>11:0</u>0 ₽^M 2011 Medical December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maple Ridge Group Home Rockville Montgomery Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Min 340-32-6981 Hours Director 1 □ M 2 🛂 F 74 11/08/1937 Mexico the Maryland notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Montgomery Rockville 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral with 15908 Maple Ridge Court 20853 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 ☐ Yes 2 XNo Mexican If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 ₺ Widowed 4 □ Divorced Specify: White Completed American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done (life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Author Books Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pascual Ricardo Sanchez Edelmira Garcia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4411 Davenport St. NW Washington, DC 20016 Amalia Jones / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 🗆 Burial 2 🕮 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2011 National Crematory Falls Church, VA 21. Signature of Fureral/Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failude. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Advanced Dementia disease or condition ears Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) transit Examil The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): burialattending physician I for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ Month Year signed by the at td be detached for Pregnant at time of death Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Parkinson's Disease, Cerebrovascular Disease, Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed should peen Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe hours after death.

uneral Director: After this certificate by filled in by the funeral director, pag 2 🗌 No Yes 2 X No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending injury 2 Accider
3 Suicide 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ompletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shyama 10 D53367 12/27/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shyamsundar Rajan MD 9801 Georgia Avenue #117 Silver Spring, MD 20902

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

DEC 29

82. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2011 3:15 P^{M} Pitt 26, Marjorie December Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's Clinton Bradford Oak Nursing Home 8. Date of Birth 9. Birthplace (State or Foreign yrs. last birthday) If Under 1 Year If Under 24 Hrs. Age (In **Funeral** (Month, Day, Year) Days Hours 84 237-46-1346 1 🗆 M 2 🔀 F **Director** 10/26/1927 Pitt Co., NC Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10a, State 10c. City, Town or Location Director 1 Yes 2 □ No Prince George's Clinton MD10f. Zip Code 0g. Citizen of What Country? 10e. Street and Number 20735 United States Funeral 7520 Surratts Road ural", or items ? I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give 1 Never Married 2 Married þ within 72 hours after Specify: Black Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 'natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 6th College (1-4 or 5+) Domestic the Homemaker other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname)
Georgia Perkins 17. Father's Name (First, Middle, Last) မ Willie Pete Joyner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5535 Marlboro Pike Apt 14 Forestville, MD 20747 item 27 Jackie Jackson (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition . Page 1 1X Burial 2 \square Cremation 3 \square Removal from State 0 permit. Page Department of Important: If any injury or Fort Lincoln Cemetery 1/4/2012 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityFort Lincoln Funeral Home 21, Signature of Funeral Service Licensee Brentwood, MD 20722 3401 Bladensburg Road Aufran PAN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Due to (or as a consequence of): Examine if any, leading to immediate

Earlie Enter Underlying

Cause (Disease or injury attending physician and I for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant led by the atter in the past 12 months? Month Day Yes 2X No 1 Yes 2X 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2X No certificate has lirector, page 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Hospital 1 ☐ Yes 2 X No 2 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: after death. Director: After injury 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 01/04/2012 D35206 1 amen ly

Registrar
DHMH 17 Rev 06-2011

State

William T Tanner 11701 Livingston Rd. Fort Washington, Maryland 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For		State of	f Marylar		artment of H		Mental Hy	giene 🤈 (43306
		State Registrar			_	Cer	tificate of L	Death		Reg. No.		
Physicia	an/	1. Decedent's Name							2. Date of De Month	ath Day	Year	3. Time of Death
Medi	cal		anita Po		h = ul				December 24, 2011 1:0			11:00 A M
Examir	ıer	4a. Facility Name (if			per)			Location of Death			ty of Death	
Funeral		Magnolia 5. Social Security N			7. Age (In yrs.	last birthday)	Lanha If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	g. Birth	eorge's place (State or Foreign
Director		579-36-5		1 □ M 2 🂢 F	82	Yrs.	Months Days	Hours Min.	(Month, Da		Coun	try)
d tow	_	Usual Residence of 10a. State	of Decedent 10b. County		100 Ci	ty, Town or Lo	l		Jan. 3	1, 1929		yland
arylan a-fsh fied a	Scto			Coores	1							0d. Inside City Limits 1 ☐ Yes 2√ No
or 28	ä	MD 10e. Street and Nun		George's	5	G	lenn Dale	2		10g. Citizen of	f What Cour	
with t	Funeral Director	6610 Be	ll Stati	on Road				769		U.S.		id y /
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Fun	11. Marital Status		12. Was Deced			Vas Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	1	ice - Americ	an Indian,
", or	by	1 Never Marri		Armed Ford 1 Yes If Yes, Give			f Yes, specify Cubar □ Yes 2 □No		Rican, etc.)		ack, White,	
ours a	Completed	3 X Widowed		Year or Dat	es.		Λ			Specii	MIIT	
72 ho In "na Medio	nple			grade completed)		(Give I	lent's Usual Occupa kind of work done d O NOT use retired)		ing	16b. Kind of	Business/In	dustry
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filed val Hyg	Be	17. Father's Name (F	First, Middle, Las	t)				18. Mother's Nam	e (First, Middle,			
ld be Menta arkec aric e	욘	Forest	Lee Pe	ddicord				Grace	Helen (Carter		
shou and is m		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mailin	g Address (Street a	and Number or Rura	al Route Numbe	r, City or Town,	State, Zip 0	Code)
and 2 Health				<u> Porter -</u>			8 Algongu	in Trail	, Lusby			
ge 1 art of the strain of the		20a. Method of Disp 1 X Burial 2		Removal from S	State C	cemetery, cren	sition (Name of natory or other place	e)	Date	20c. Location		
nit. Pa artme ortani injury		4 Donation 5 Other (Specify) Ft Lincoln Cemetery 12-28-2011 Brentwood, Mar										
permit Depar Impor any in		21. Signature di Ful		MICO	Door	V I	. Name and Addres	Be	all Fund			
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hysician/		Immediate Cause (I	Final	one cause on eac	1 5	() or	o no	+1				Interval Between Onset and Death
Medical		disease or condition resulting in death)	n 🗸	a. Due to (o	r as a conseq	U W	10 /00	ing				years,
Examiner	_	Sequentially list cor	nditions	Con	cresti	VY h	court	Failu	ne			recul,
ti.	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										, ,
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be ex sician buria												
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nding use a	ln/N	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outco			1			23d. D	ate of delive	erv
e atte	sicia	in the past 12 n 1 🔲 Yes 2 🗓			irth 2 ∐ Feta ant at time of o		Ectopic pregnancy Other (specify)	<i>∮</i>		M	onth	Day Year
by the stacker	Physician/Medical	9 Unknown							1			
ignec be d		Part II. Other signifi	cant conditions	-			nderlying cause give	en in Part I.	_			e cause of death?
peen s	etec		- (V) - (, , ,	1 100			1 🗆 \			pably 4 Unknown
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s certi	To Be	examiner?	ŽNo	Hospital:	nationt 2	ER/Outpatien	Othe	ce of Death (Check			(0	
ter this		27. Manner of Death		28a. Date of		28b. Time of	28c. Injury	at	me 5 Resid			1
ending sath. or: Aft	fical	1 ☑ Natural 2 ☐ Accident	5 Pending Investigati	on	, Day, rear)	injury	M 1 🗆 Y	Yes 2 No				
fter de irecto	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	√ 28e. Place o	f Injury - At ho		et, factory, office		28f. Location (S City or Town		er or Rural	Route Number,
viting the proposal of Attentioning Proposals. The law requires that the beart between the withing at the two states death. To the Funeral Director, After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial proposals.	SalC	00. 0. 115	· 16									
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vithin Fo the	Σ	only one) 3 29b. Signature and t	1	rse Practitioner:	to the best of r	ny knowledge,	death occurred at th			ne cause(s) and 29d. Date signe		
- , - O			OATEL	and	101	MD				121	27	111
à		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAKESH ARORA MD 14300GALLAM FOXLN#222 BOWIE MDZO 715										
1/10		KAKES	HAR	ORAM	D14	300 G	ALLAN	T FOXL	N#222	BOWI	EMD)	20715
Stat Registra	e	31. Date filed (Month	, Day, Year) ここってつい		gistrar's Signat	ture	at A					

DHMH 17 Rev 06-2011

Amend #10e per			Гуре or Pri							-		_	ble.	
AACO Health Dep	pt d	. (2-29-11 KAH For L_ State	State of M	arylar	-				and M	lental Hy	/giene	20		43307
		State Registrar 1. Decedent's Name (First, Middle, Last)			Cer	titical	te of L	Death	-	2. Date of D	Reg. No	. 2 0	i i	
Physician/ Medical		Ada L. Peters									Date of Death Month Day Pear 27 2011 3. Time of Death 5:45 AM			
Examiner		4a. Facility Name (if not institution, give st	reet and number)		_	4b. City	, Town, o	r Location	of Death	Decem	4c. County of Death			4 3 13 11
		Future Care Che				Arnold				Anne Aru				
Funeral Director	1	5. Social Security Number 6. Sex 083-36-7356	7. Ag] M 2 X] F		last birthday) 96 Yrs.	Months	Pr 1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bi	rth av Year)	915	9. Birth	place (State or Foreign htry) W York
A A	Ì	Usual Residence of Decedent	30 116.						1 200 20 1313					
Irylanc I-f sho lied at		10a. State 10b. County Maryland Anne Ar	undel		ty, Town or Loo nnapol								1	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
or 28% or potition of Direction	-	10e. Street and Number		111	- Inapor		p Code				10a Cit	tizen of Wh	nat Cour	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		1903 Marionar Co	ri Pole				2140	1			rogi on		SA	y.
death ritem ner n			2. Was Decedent E Armed Forces? 1 \(\sum \) Yes 2 \(\bar{X}\)	ver in U.	S. 13. V	Vas Dece f Yes, spe	dent of Hi	ispanic Or ın, Mexicai	igin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)	-	14. Race	- Americ	
Maryland 21215-0036 2 should be filed within 72 hours after d th and Mental Hygiene. 27 is marked other than "natural", or i traumatic event, the Medical Examin To Be Completed by		1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XX If Yes, Give Year or Dates.	No				Specify				Specify:		ack
21215-003 uithin 72 hours at lene. r than "natural" the Medical Exa	<u> </u>	15. Decedent's Edu (Specify only highest grade	cation		16a. Deced	lent's Usu	al Occup	ation			16b. K	ind of Bus	iness/In	dustry
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be fill ental rked of Ice ever		John Lane								(First, Middle ed Fie		Surname)		
lary	İ	19a. Informant's Name/Relationship (Type	e, Print)		19b. Mailin	g Addres	s (Street a	and Numbe	er or Rura	Route Numbe	er, City or	Town, Sta	te, Zip C	Code)
nd 2 s		Joyce E. Brown(Daughte					i Ci	rcle	a Anna	po1	is,	Md.	21401
Baltimore, semit. Page 1 and Department of Hea mportant: If item iny injury or other	2	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20R.0	DSOf DHo cemetery, crem emoria	sition (Sai natory or o	me of other plac	e)		ate	ı	ocation - C	-	
Iltin	-	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		Me					1-4-					ley, NY
Ball permir Depar Impor any ir	21. Signature of Funeral Service Licensee Winame Ressent Reliations Mortuary, P. A 1922 Forest Dr. Annapolis, Md.										21401			
10000	†	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused	the deat				_				J , 11		Approximate
Physician/		Immediate Cause (Final disease or condition	Sadoo on Gaon inic	0	206	4	de	.10						Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or all a	conseq	uence of):	1								-
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auth certificate be atth certificate be attending physici I for use as the bu cian/Medica		d												
certification use as use	1 2	F FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome	of pregna	incy	1 -						23d. Date	of delive	env
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burned and the funeral Certificate: To Be Completed by Physician/Medical		in the past 12 months? 1 Yes 2 No	1 Live Birth 4 Pregnant at 9 Unknown	time of	death 3 L death 5 L	Other (s)	pregnanc pecify)	у				Month		Day Year
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Records, The law requires cate has been sig page 2 should t		Denesti	-)							24a, Was	an /			osy findings available
/ital Reco	-	STATE								auto perfo	psy ormed? 2 No	prid dea	ath?	mpletion of cause of
Vital I ysician: 1 s certifica director, p	2	25. Was case referred to medical examiner?						ace of Dea	th (Check		2 J 2 -NO		_ ies	2 L NO
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on on ording the stane efune	1	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	Year)	28b. Time of injury	M 2	8c. Injury work?			8d. Describe h	now injury	occurred		
Division of Vital Records, all or Attending Physician: The law requires is after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be a completed to be Completed to be completed to be completed to the completed to be completed to be completed to the completed to be completed to the complete to the completed to the complete to the	ı	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc			et, factory			_			Number	or Rural	Route Number,
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Division of To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certificate:	2	29a. Certifier 1 Certifying Physici (Check 2 Medical Examiner only one) 3 Certifying Nurse I	r: On the basis of ex	amination	and/or investi	oation, in a	my opinio	n, death oc	courred at t	he time, date a	and place	and due to	the cau	ise(s) and manner stated
To the within To the comple	2	9b. Signature and title of certifier												
		> money	[m,			17	05.	753	1		Dec	en	G-C.	-28,200
301	3	0. Name and address of person who com	pleted cause of de	ath (Item	23a) (Type, Pr	int)	5	-	_				_	28, 201, 28, 201, 21108
State	3	1. Date filed (Month, Day, Year)	32. Redistrai	's Signat	ture,	1	Ky	7, 1	nell	eyson	u	1	1D	21108
Registrar		DEC 2 9 201	1 Dense	ر ا	A. 1	arks	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar L3308 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Physician/ 5:25 P M DECEMBER PETER PAUL PUZAK II Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) Months Days Hours Min **Director** 217-60-6892 1 X M 2 - F PENNSYLVANIA 59 07/09/1952 Usual Residence of Deceden items 23a or 28a-f shov ier must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MARYLAND ANNE ARUNDEL ARNOLD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 280 PENINSULA FARM ROAD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: er than "natural", the Medical Exa Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 ENGINEER ENGINEERING Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ PETER P. PUZAK FRANCES JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA PUZAK/WIFE 280 PENINSULA FARM ROAD, ARNOLD, MD 21012 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State BESTGATE MEMORIAL 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/30/2011 ANNAPOLIS, MD 21. Signature of Funeral Service TING ROAD Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, shock, or heart failure dist only one cause on each line. Onset and Death Immediate Cause (Final Ptrywittian/ disease or condition resulting in death) Medical Due o (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical requires that the death certificate be P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy perforn death? 1 Yes 2 No __ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature and title of certifier 00057635 mo 20, 30. Nam dress of person who completed cause of death (Item 23a) (Type) Print)

Registrar

31. Date filed (/

2 9 2011

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43309 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Pritchett 2103 2011 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bultimore of Maryland Medical . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) Director 5 -10-Maryland Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Caroline 1 ☑ Yes 2 ☐ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Maryland 21215-0036 Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. 3 Divorced Completed th and Mental Hygiene. 27 is marked other than "natul traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) employed area Ver Be 17. Father's Name (First, Middle, Last) မ ence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur I Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traconce. Marce Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other 4 Donation 5 Other (Specify) Men. permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Henry Funeral Ita HOME, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph si i n Valve tortie disease or condition dows Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed been a Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy within 24 hours after death.

To the Funeral Director: After this certificate be completely filled in by the funeral director, pag Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 X No 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniurv 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/24/11 CRNR R195325 30. Name and address, of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Mont

DEC

Baltimore

MD

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Greene St.

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle 2. Date of Death 3. Time of Death Physician/ Month CO M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 12810 Talley Lane Darnestown Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign (Month, Day, 1 M 2 X F Days Hours New York Director 99 088-56-3798 1912 Aug Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12810 Talley Lane 20878 United States 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3₺ Widowed 4 □ Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rosario LaScala Rosalia Catania 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette DeRosa (Daughter) 12810 Talley Lane, Darnestwon, MD 20878 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery 12/23/2011 Bronx, New York 22 Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 . Signature of Funeral Service art 1. Enter the disease, or complications at caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause n each lin Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or ás a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery Live Birth 2 Line recarded.

Pregnant at time of death in the past 12 months? Day Year i signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has by page 2 s prior to death? autopsy performed certificate Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Yes Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) ē 27 Manner of Death 28a. Date of injury (Month, Day, Year) Time of Certificate: within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral 1 Natural 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Full Gertifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 28a) (Type, Print) F. Schroeder M.D Arthur PHISIC

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ Month Jane Ellen Robertson December 2011 12:40 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Emmitsburg Frederick St. Catherines Nursing Center Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Dec. 11, 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign Days Min Hours 1915 Maryland Director 219-20-1498 96 Usual Residence of Decedent shov 10a. State 10b. County ŧ 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified Maryland | Frederick 1 X Yes 2 No Emmitsburg 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a on event, the Medical Examiner must be Funeral 331 South Seton Avenue USA 21727 Department of Health and Mental Hygiene.
Important: If item 27 is marked out. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 XNo Specify. Specify: Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Weaver Silk Mill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lillian Pryor Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Britner (Daughter) 2997 Evitts Creek Road Bedford, Pennsylvania 15522 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park Jan.3, 2012 Williamsport, Maryland 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, 1 CEMI Ef Onset and D at Immediate Cause (Final Pusician/ 104 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ue to (or as a con equence of) Examin -tran and Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical certificate be the ass IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ò in the past 12 months? Dav Pregnant at time of death 21× No the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ The law requires Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No certificate ieric 1 Yes 2 No or Attending Physician: 25. Was case r ferred to medical Be 26. Place of ath (Check only one) examiner? Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this eral Director: After th filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury hours after death. 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State To the Hospital within 24 hours a

Box 68760

P.O.

Records,

Division of Vital

State Registrar

Medical

29a, Certifier

3 [

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

29b. Signature and title of certifier

a

31. Date filed (Month, Day,

egistrar's Signatu

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

201

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 404 CAKE Game 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days 4 /2/1938 Min 1 🔀 M 2 □ F Pennsylvania Yrs Director 73 83-28-3306 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No <u>Mountain</u> Lake Park Garrett MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21550 404 N Street 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Banker Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Stewart Margaret Paul Raybold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 404 N St. Mtn. Lake Park, MD Nancy Raybold/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Congress to graphs dependent place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Davidsville, PA 12/31/11 4 Donation 5 Other (Specify) Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. Second St., Oakland, MD 203 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nset and Dee Immediate Cause (Final Physician/ onelle mania disease or condition resulting in death) Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burialending physician a use as the burial-Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 5 Other (specify) Pregnant at time of death ☐ Pregnant 1 Yes 2 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Records, 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy performed this certificate Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: of D Natural 28d. Describe how injury occurred work? 5 Pending n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) le 15 of death (Item 23a) (Type, Print) person who comple

Registrar

State

Date filed (Month, Day, Year)

82. Registrar's Signature

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day Year)

28 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dec. 23ª 20 F 4:31 Schultze Ам Michael Brian Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 702 Chapelgate Drive Anne Arundel Odenton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 227-96-6413 51 **Director** 1 🛛 M 2 🗆 F 11/01/1960 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Odenton Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 702 Chapelgate Rd. 21113 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. by 1 X Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates. 80-84 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 System Analyst Dept. of Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Henry Schultze Virginia Lee Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marti Salvador (Aunt) 19148 Fairway Ct. Turlock, CA 95380 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or other 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 12/26/2011 | Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Deensee 22. Name and Address of Facility Hardesty Funeral Home 77 d -851 Annapolis RD Gambrills, MD 21054 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ESOPHERED CONCER Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed g physician and as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending of be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 L Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been signal director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital: 2 No 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Pay, Year) DO064852 mo of person who completed cause of death (Item 23a) (Type, Print) 84 RAVIN GARG 2003 Medical Pkwy Suite 210 Annapolis, MD 21401 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 14:44 P M 20. <u>Antonio John Ristaino</u> Dec. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Social Security Number 7. Age (In yrs. last birthday) (Month, Day, Year) Director 217-16-4300 1 X M 2 □ F 86 May 26,1925 Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Anne arundel Annapolis Maryland| 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21409 4 Arlie Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Was Decedent Ever in U.S. 14 Race - American Indian ☐ Yes 2 X No If Yes, Give X No Year or C Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 😾 Widowed 4 🗌 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Chemical Engineer Air Force 5+ and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincenza Alvino Carmine Ristaino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7028 Heathfield Rd., Baltimore, MD 21212 $\,$ Tony Ristaino / Son or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) St. Mary's Cemetery 12/27,2011 Annapolis, MD 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Signature of Funeral Service Licenses 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Asystol-c 1-) rest MINUTES disease or condition Medical resulting in death) Examiner MINUTES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Encopolop. 1 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy Was case referred to medical examiner? performed Yes 2 death? 25. Was Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA e Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th oletely filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year)

ED 10.

Baltimore, Maryland 21215-0036

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Division of Vital

Registrar
DHMH 17 Rev 06-2011

31. Date filed (Mor

istrar's Signature

2001 Medical Parkway, Annapolis,

21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KANAK PATE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 231, 2011 Physician/ 3:23P M DORIS ERNESTINE SNEAD Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Greater Baltimore Medical Center Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 11-10-1949 Hours Min 217-62-9040 **Director** 1 ☐ M 2**X** F MD. 62 Usual Residence of Decedent or 28a-f show notified at the Maryland 10c. City, Town or Location Director 1 Yes 2 No MD. BALTI.CITY BALTIMORE 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be r Iral", or items 23a Examiner must be Funeral 2909 LINGANORE AVE. 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: Specify:BLACK Completed 3√ Widowed 4 □ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) NURSES AIDE NURSING HOMES 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HOWARD WILMER LEE MARY ANNE WATTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBIN HOFFMAN-DAUGHTER 8600 PAPS PARKWAY LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HERITAGE MEM.CEM. 1-13-12 WALDORF, MD. Signature of Ineral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death 15chema Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by anema 1 Yes 2 No 3 Probably 4 Unknown diabetic ketoacidosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy renal performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending P¹ 24 hours after death. e Funeral Director, After ti 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29c. License number Cynaria Smann 13 00057347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YNFMA SOCANOMO 6261 NCM 6201 NCharus St Baltimore MB 32. Registrar' Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29 2011 **Physician** 9:25 Wilhelmina McClain Smith December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood Nursing Home Williamsport Washington County 8. Date of Birth (Month, Day, Year) April 10,1924 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 87 yrs. **Funeral** Min. Hours Months Days 1 □ M 2 🗓 F Mary Land 217-12-2628 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17502 York Rd. 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □ Yes 2 X No Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Board of Education marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fill Health and Mental H tem 27 is marked otl Lawerence Edward McClain Muriel Causher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10730 Greenwich Dr. Williamsport, MD 21795 Judy Semler-niece Department of Health Important: If item 27 any Injury or other to once. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 1-4-2012 Rose Hill Cemetery Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Lige 1331 Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or co.n. cations that caused the death. shock, or heart failure. List only one cause on each in e. Do not enter the mode of dying, such as expliac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Box 68760. physician Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₫ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy performed? 1 Yes 2 No certificate this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? he Hospital or Attending P n 24 hours after death.
he Funeral Director: After t pletely filled in by the funera 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

To the within 2

License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DEC <u>Stottlemyer</u> Medical <u>Jean</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Liberty Street Social Security Number 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Days Hours 1 🗆 M 2 💢 F Months Northern Ireland Yrs Director 220-28-2926 88 Dec. Usual Residence of Decedent 28a-f show 10b. County 10a. State 10d. Inside City Limits the Medical Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 ☐ No Hagerstown <u> Maryland Washington</u> 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21740 USA 521 Liberty Street "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White If Yes, Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) Dress Factory 12 Seamstress permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Annie Brush <u> Andrew Creighton</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 Liberty Street, Hagerstown, Maryland 21740 Ralph Stottlemyer - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hagerstown Crematory 12/30/11 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland Signature of Funeral Service Lice 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. val Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury and -transit Exami that the death certificate be executed that initiated events resulting in death) Last Physician/Medical 68760 the d guipt se as t IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregna 5 Other (specify) Ectopic pregnancy jo in the past 13 mont Month Day Year Pregnant at time of death 9 Unknow 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, To the Hospital or Attending Physician: The law requires 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 2 5 Residence 6 Cother (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sia 29c. License number 1946622 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4236 MORROWVIEW DR ARBERTONN MD 21742 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 43320 State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2011 Harry Clayton Snook 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown 1452 Potomac Washington Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** June 29 1 XM 2 - F Months Days Hours Year 1921 215-26-1302 90 Maryland **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Y Yes 2 ☐ No Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1452 Potomac Avenue 21742 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian Black, White, etc "natural", or 1 Never Married 2 Married Completed by Yes, Give 2 🗆 N Maryland 21215-0036 1942-1945 1 ☐ Yes 2 X No Specify. White Specify: 3 XWidowed 4 Divorced Year or Dates. the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Poultry Business Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Virginia Startzman Norman Jacob Snook 1 and 2 should be of Health and Me item 27 is mark other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry N. Snook Son 1812 Brightwood Drive, Hagerstown, Maryland 21742 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
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Rose Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State 01-03-12 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 21. Signature of Funeral Service Licensee R. hoel Brady 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ MYOCARDIAL INFARCTON disease or condition Medical resulting in death) **Examiner** YEMY COMOMMY Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-tran: it Hospital or Attending Physician: The law requires that the death certificate be executed DEBILITY YEMY that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) been signed by the same should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 performe 2 🗌 No Yes 2 X No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: ၉ 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & MOIR 20311 IW-10+1 6/mm 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

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State of Maryland / Department of Health and Mental Hygiene 2.0 1

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e) O	and 2 Health em 27 ther to		Robert Joel Pomeranz - Spouse			<u> Parkwai</u>	1			land 20815	
Baltimore,	Page 1 ment of I ant: If it ury or o		1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State		natory or other place		Date	20c. Location -	,		
alt	T									h, Virginia Home, Inc.	
<u>m</u>	Depar Impor any in		Rathing Junque	lampshire	L Ave., S.	ilver Sp	ring	, MD 20904			
			23a. Part 1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.	leath. Do not ente	er the mode of dying	, such as cardiac	or respiratory arm	est,		Approximate Interval Between	
F	h, sician/ Medical	l, II	Immediate Cause (Final disease or condition resulting in death) a. Glioblas		ti/orme					Onset and Death 3 Years	
تجسب	Examiner		Due to (or as a cons	sequence ot):							
1200	t= 0	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):							
	and	Examiner	Cause (Disease or injury that initiated events c	reguence of:					_		
0	ate be executed bhysician and the burial-transit	dical E	resulting in death) Last	sequence on.							
3760	triat the death certificate be executed ned by the attending physician and edetached for use as the burial stransity.	/ledi	d								
89 x	requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ I		Ectopic pregnancy	/			e of delive	1	
Box	e deat the att	ysici	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	of death 5	Other (specify)			Mor	ith	Day Year	
О	ed by detac	y Ph	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to th	e cause of death?	
	uires t in sign uld be	ed by			-		1 🗆 Y	es 2 🗓 No	3 🗌 Prob	ably 4 🗆 Unknown	
50.0	The law requires ate has been sign page 2 should be	Completed					24a. Was a			sy findings available inpletion of cause of	
Ě	rhe raw cate has page 2	Corr					perfor	med? d	eath?		
ta :	sician: The certificate irector, pae	Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Othor	ce of Death (Chec				Secondary Residence	
o t	a Fnys er this ieral di	e: To	27. Manner of Death 28a. Date of injury	28b. Time of	it 3 L DOA	4 U Nursing H	ome 5 Resid	ence 6 X Other		Residence.	
on	aath. or: Afte he fur	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year, 2 ☐ Accident Investigation) injury	M 1 □ Y	yes 2□No					
Division of Vital Records,	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location (Si City or Town	reet and Number n, State)	r or Rural	Route Number,	
ַ בֿ	r nospital or Attending Priysician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director,		29a. Certifier 1 💢 Certifying Physician: To the best of my kn	owledge, death o	occurred at the time.	date and place, a	and due to the car	use(s) and manne	er as state	d.	
=	ne no in 24 h he Fur pletely	Medical	(Check 2 Medical Examiner: On the basis of examinational only one) 3 Certifying Nurse Practitioner: To the best	ation and/or invest	igation, in my opinior	n, death occurred a	t the time, date ar	d place, and due	to the cau	se(s) and manner stated.	
	to the rospital or Attending Prystician: In within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pa		29b. Signature and title of certifier		29c. License			29d. Date signed			
		X.	J/0011			D0023600	,	Vecen	1ber	21, 2011	
			30. Name and address of person who completed cause of death (I Bruce Kressel, M.D., 5530 Wi			1125, Be	ethesda.	Marylar	nd 20	815	
	Stat		31. Date filed (Month, Day, Year) DEC 2 7 2011	naure La	es.						
	Registra		IIII. 27 ZUII Yearn	W. 75							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Stokes Katherine В. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Chevy Chase Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Jan. 31, 1927 Days Min. 1 □ M 2 💢 F Director 84 Yrs OkTahoma 215-38-5491 Usual Residence of Decedent or 28a-f shov notified at 10c. City, Town or Location 10b. County Director Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 20815 8700 Jones Mill Road United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? 1 Yes 2 X No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mail Clerk Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harriet Genevieve O'Neill Camillus Baker Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Duvall (Nephew) 13833 Piedmont Vista Drive, Haymarket, VA 20169 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) January St. Mary's Cemetery 2012 Rockville, MD Signature of Euneral Service Licensee 22. Name and Address of Facility DeVol Fuenral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Breast Cancer Metastatic to Bone disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Medical Certificate: To Be Completed by Physician/Medical Examine Due to (or as a consequence of): rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Completed filled in by the funeral

cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		topic pregnancy her (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions c	ontributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Chronic Lymphocy	tosis: Leukemia		1 ☐ Yes	2 No 3 Probably 4 K Unknown
			24a. Was an autopsy performed?	
25. Was case referred to medical examiner?		26. Place of Death (Check	only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3	Other: 4 X Nursing Hon	ne 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident □ Investigation		28c. Injury at work? M 1 Yes 2 No	8d. Describe how inju	ury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office 2	8f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, te)
(Check 2 Medical Exam	sician: To the best of my knowledge, death occu iner: On the basis of examination and/or investigati se Practioner: To the best of my knowledge, death	ion, in my opinion, death occurred at t	he time, date and place	ce, and due to the cause(s) and manner stated.
29b. Signature and the of certifier		29c. License number	ate signed (Month, Day, Year)	

D35579

43323

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3. Time of Death

10d. Inside City Limits

Interval Between Onset and Death

12/27/2011

White

1 🗌 Yes 2 🗓 No

6:50

State Registrar 31. Date filed (Month, Day, Year) DEC 2 9 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Susan J. Miller, M.D., 8218 Wisconsin Avenue #305, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of Mary			of Health of Death		•	giene Reg. No. 20		1,3321
Physic		1. Decedent's Name (First, Middle, Las	Maria Sza	lai				2. Date of De- Month Decemb		ear	3. Time of Death————————————————————————————————————
/Medi Exami		4a. Facility Name (If not institution, give		3	4b. City,	Town, or Locatio	n of Death	<i>-</i>	4c. County of		-
		Collingswood Nur					ville				omery
Funeral Director		114-30-3977	ex	yrs. last birthday Yrs.	Months	Days Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day, Year) 9. Birth (Col. 08 / 26 / 1923			ce (State or Foreign y) Ukraine
and w		Usual Residence of Decedent 10a, State 10b, County	100	. City, Town or I	_ocation					100	d. Inside City Limits
Maryli f sho	ō	Maryland Montg	Cim O tr II	•		Rockvi	000				1 ☐Yes 2 ☑ No
r 28a	Directo	10e. Street and Number	ometg	·	10f. Zip		···		10g. Citizen of Wha	at Countr	y?
h with		4805 Creek.	Shore Drive			20	852			u.s.	Α.
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural" or Items 23a or 28a-f show matte event, the Medical Examination and the resilies of the matter o	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 □Yes 2 ★ No If Yes, Give	in U.S. 13	8. Was Deced If Yes, spec 1 ☐ Yes 2	ent of Hispanic (ify Cuban, Mexic		ecify Yes or No Rican, etc.)		White, etc	э.
ours ural";	d by	3 🐼 Widowed 4 □ Divorced	Year or Dates:				·y·		Specify:		vhite
15-1	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Giv	edent's Usua re kind of wor . DO NOT us	k done during m	ost of worki	ing	16b. Kind of Busir	ness/indu	istry
withir iene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	inc.		teria Se	rvice		i	Bank	ina
ifiled v I Hygie other t	Be C	17. Father's Name (First, Middle, Last)		1	550				, Maiden Surname)		
arylan should be ind Mental marked o	To B	Та	ras Saluk					Motri	ja Rudyk		
Marylo	0	19a. Informant's Name/Relationship (er, City or Town, St		
s 1 and of Health item 27		Natalia Kormeluk					_	e, Rock	ville, Ma		
timore, Maryland 21215-0036 i. Pages 1 and 2 should be filed within 72 hours aft riment of Health and Mental Hygiene. rath: if them 27 Is marked other than "natural", or hipry or other traumatic event, the Markel Event Ev		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		0b. Place of Disposer cemetery, cr			_				
Baltimo permit. Page Department of Important: If any Injury or once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer	1500 /						Suitland		rykana Iome, Inc.
Balt permit. Departition on the permit any injury i		AnneManu	Warner 1	lew Hamp	shire	Ave., S	ilver Spr	ing,	MD 20904		
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not e	enter the mod	e of dying, such	as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a CARDIO		ATHY						
Examiner			Due to (or as a co	. ,	MOLL	TILC					
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a so.	7.E.S. risaquerios of):	rifico	100					
cuted	Examiner	Cause (Disease or injury that initiated events	c. HYPE	RTENSI	on.						
68760, ificate be executed g physician and is the burner	Ë	resulting in death) Last	Due to (or as a cor	nsequence of):							
68760, ificate be ex g physician is the burien	edical		d							-	·
	/We	IF FEMALE:	23c. If yes, outcome of pr	regnancy					23d. Date	of deliver	v
Box death cer attendin	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 100	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		B ☐ Ectopic p D ☐ Other (sp				Mont		Day Year
P.O.	hysi	9 □ Unknown	9 🗆 Unknown								
Vital Records, P.O. Box sician: The law requires that the death cert certificate has been signed by the attending rector, page 2 should be detached for use a	þ	Part II. Other significant conditions of	ontributing to death but no	t resulting in the	underlying ca	ause given in Pa	rt I.		tobacco use contrib Yes 2000 3		e cause of death?
aw rec as bee 2 shou	Completed							24a. Was		ere autop	sy findings available
of Vital Rec hysician: The law his certificate has I director, page 2.9	mo							auto perfo 1 □Yes	ormed? de	ath?	pletion of cause of 2 No
ita itan: ertifica etor, p	Be C	25. Was case referred to medical examiner?				26. Pl	ace of Deat	h (Check only			
of V hysic this co		1 ☐ Yes 2 🖾 Alo		2 ER/Outpat			Nursing Ho		idence 6 ☐ Other)
On C	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Ye	ar) 28b. Time Injury	of 2	8c. Injury at ⁷ Work? 1 ∐Yes 2	ПМо	28d. Describe	how injury occurred	ı	
Division of I or Attending Physiafter death. Director: After this d in by the funeral di	ficat	2 Accident investigation 3 Suicide 6 Could not be		At home, farm,				28f. Location	Street and Number	or Rural	Route Number.
Division of Vita vithe Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific, completely filled in by the funeral director, it	Certification: To	4 Homicide determined	building, etc. (S	pecify)				City or To	wn, State)		
Hosp 24 hor Fune stely fi	Medical		nysician: To the best of my niner: On the basis of exa and manner stated.								
Fo the vithin of the comple	Med	29b. Signature and title by certifier	and manner stated.		290	:. License numbe	er		29d. Date signed (Month, D	Day, Year)
8	1	1 that				X 3013	5		19/10	hi	
	i	30. Name and address of person who	completed cause of death	(Item 23a) (Typ	e, Print)				//		
		MERITA RHOSH 14	completed cause of death	WS LAN	E # 161	, ROCK	CUILL	E MD	3450		
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Hegistrar's S	signature /	dit.	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Registra MEND#17perFH, 12/29/11; BMV, MoCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eloise Elizabeth Bradford Smith 4:15a M 2011 Dec. 27, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth F (Month, Pay, 15) 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 915 1 M 2 kg F 354-24-1220 96Yrs Arkansas Director Usual Residence of Decedent 10c. City, Town or Location Charlottesville 10a. State VA 10d. Inside City Limits Director Albemarle or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 X Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country Funeral 22901 States United 1542 Birnam Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 African 1 ☐ Yes 2 No Specify. If Yes, Give Completed 3 K Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)
Teacher al Hygiene. Education Elementary/Seconday (0-12) of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 17. Fathar Same (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ aze Robin Bradford Mattie Winfrey pe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zig Code) 1542 Birna m Drive, Charlottesville, VA 22901 permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Kellie E. Palmer / Great Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 K Removal from State 1/02/2012 Norfolk, VA Woodlawn Memorial 4 Donation 5 Other (Specify) Funeral Service, Inc. Washington DC 20012 of Funeral Service License 22. Name and Address of Facility Signature McGuire 7400 Georgia Avenue, NW, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Malia Physician/ Medical Due to (or as arco sequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial-Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? the Funeral Director: After this certificate has been signed by the atterpleted filled in by the funeral director, page 2 should be detached for 1 Yes 2 I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ **Completed I** 1 Yes 2 x No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 3 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 \square Nursing Home 5 \square Residence & Other (Specify 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Medical Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Hospital or Attending 1 XI Natural injury 5 Pending 2 🗌 No М 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and ti address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43326 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 31, 2011 Phillip Kenneth Snow, Jr. **Medical** 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Aug • 9 **Funeral** 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign 1XXM 2 - F Pennsylvania Director 164-30-3621 74 Aug. Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director allo be moc.

d Mental Hygiene.

marked other than "natural", or items 23a or 28a-ı ⇒

marke ovent, the Medical Examiner must be notified Maryland Washington Co. Smithsburg 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21926 Leitersburg Smithsburg Road 21783 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Water Treatment Co. Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Phillip Kenneth Snow, Sr. Nina Wareham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ~21/83Mary Jane Snow / Wife 21926 Leitersburg Smithsburg Road Smithsburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park Jan. 6,2012 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. N. Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ralignant 60 hours Medical Examiner Coronan Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit respic Due to (or as a consequence of): resulting in death) Last Medical To the Hosp tall or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Fune all Director: After this certificate has been signed by the attending physicial completed filed in by the funeral director, page 2 should be detached for use as the burn completed filed in by the funeral director, page 2 should be detached for use as the burn completed filed in the surface of the state of the surface of the state of the surface of the s Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed aravi3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of co 29d. Date signed (Month, Day, Year) 10056379 1-4-20/2 30. Name and address of persol who completed cause of death (Item 23a) (Type, Print) 5530 Wise. Ave \$700 Chevy Chase, ms rshall MI 31. Date filed (Mont State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3<u>0 2011</u> Month Lewis Dalone Stitt 12 12:38 pM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges County Hospital Cheverly Prince Georges 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours 378=98**-**9657 1 🔀 M 2 🗆 F Michigan 38 Nov.19, 1973 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland | Prince Georges Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 Warfield Dr., #4092 20785 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Hutchinson Darlene R. Stitt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17748 01/03/12

Completed cause of death (Item 23a) (Type, Print)
PRICE, NO 1330 New HAMPShire AX NW #12/WD

Physician/ Medical Examiner 1 - For State Registrar

10a. State

Physician/

Medical

Examiner

Funeral

Director

show

-28a-f

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permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be a may injury or other traumatic event, the Medical Examiner must be a

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

notified at

Director

Funeral

ò

Completed

Be

2

19a. Informant's Name/Relationship (Type, Print)

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician

Examiner Physician/Medical Completed by Medical Certificate: To Be n 24 hours after death.

e Funeral Director: Af
bletely filled in by the fu

29b. Signature and title of ce

Antonio J. MAy/ F	riend	1 41	0 Warfi	eld Dr	<u> </u>	_ Lan∂ov	rer. Md.	20785
20a. Method of Disposition		20b. Place of E			Da	te 2	0c. Location - City	or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			t Mem.P		Jan,7	,2012	Redford,	MI.
21. Signature of useral Service Licensee	- //22 4	1-2		d Address of Fac	Ever	ly Whea	itley Fund	eral Home
1 m	7 MOI	202					adria, Va	
23a. Part 4. Enter the disease, or complice shock, or heart failure. List only one	cause on each line.	ne death. Do noi	enter the mod	e of dying, such a	is cardiac or r	espiratory arres	t, •	Approximate Interval Between
Immediate Cause (Final disease or condition	Meta:	static	Lec	tal 5	au An	mis C	traces	Onset and Death
resulting in death)	Due to (or as a	onsequence of)	10.00					7
AND ADDRESS OF THE PARTY OF THE	HIV	inFe	CHO	4				10 year
if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onsequence of)						7
Cause (Disease or injury that initiated events								
resulting in death) Last	Due to (or as a c	onsequence of)						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal death	3 Ectopic 5 Other (sp				23d. Date of o	delivery Day Year
Part II. Other significant conditions cont	ributing to death but	not resulting in t	the underlying	cause given in Pa	rt I	03a Did taha	and use contribute	to the cause of death?
Taren. Other signmount conditions con	ributing to death but	not resulting in	ine andenying (Jause giveii iii Fa		1 \(\sum \) Yes		Probably 4 Unknown
					-	I L ies		
						24a. Was an autopsy		autopsy findings available o completion of cause of
						perform	ed? death	
25. Was case referred to medical				26. Place of De	eath (Check o		ANO I L	2 2 110
examiner? 1 \(\sum \) Yes 2 \(\sum \) No	spital:	2 X ER/Outp	etiant 2 🗆 D	Other		· · · · · · · · · · · · · · · · · · ·	ce 6 C Other (Sp.	
27. Manner of Death	28a. Date of injury	28b. Tim		8c. Injury at			injury occurred	есіту)
1 Natural 5 Pending 2 Accident Investigation	(Month, Day,)	<i>(ear)</i> inju	iry M	work?		a. Describe flow	injury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm Specify)	, street, factory	, office	28	f. Location (Stre City or Town,		Rural Route Number,
29a. Certifier 1 Certifying Physic	an: To the best of my	knowledge, de	ath occurred at	the time, date ar	nd place, and	due to the caus	e(s) and manner as	stated.
(Check 2 Medical Examine only one) 3 Certifying Nurse	r: On the basis of exar	nination and/or ir	nvestigation, in a	my opinion, death	occurred at th	e time, date and	place, and due to th	e cause(s) and manner state

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 15 ann STEPHENSO YLVIA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 578-40-4714 78 Yrs Director 1 □ M 2 1 F March 15,1933 Washington DC Usual Residence of Decede 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Bethesda Montgomery 1 Z Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9801 Bristol Square lane #103 20814 USA be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. ö þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) N.I.H the Microbiologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ည Marie I. Frazier Wesley T. Stevenson Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 2932 Terr. Dr. Chevy Chase MD 20815 Betty M. Masket/Friend 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/06/2012 Laurel, MD Maryland National 22. Name and Address of Facility Tyrone J Young Funeral Services 21. Signature of Funeral Service Licen 5635 Eads Street NE Washington DC tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. r complications that caused only one cause on each line . Enter the disease Approximate Interval Between k, or heart failure. List only Immediate Cause (Final disease or condition Onset and Death terrosclentie Physician heurt Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 12/24/11 DUSAM Examine Due to (or as a consequence of): use as the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day signed by the ar Yes 2 🖊 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Via Stephenson plnous 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Director: After this certificate has director, page 2 autopsy perform Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No မြ 1 Inpatient 2, ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or At within 4 hours after of To the Funeral Direct completely filled in by 4 \square Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D055480 29.201 pleted cause of death (Item 23a) (Type, Print)

State

Registrar
DHMH 17 Rev 06-2011

rendon

JAN 0 4 2012

31. Date filed (Month, Day, Year,

32. Registrar

Carrolly 8600 Old Georgetown Rd. Bethesda MD 20814

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type or F								} _		
		For State		State of	Marylan		artment of I tificate of I		i Mentai Hy	giene Reg. N		1 100	20	
, DI	,	Registrar 1. Decedent's Name					imouto o		2. Date of De	eath	ay Year	3. Time of Dea	ath	
Physicia Medic	al			nith			4 07 Tours	- L stine of Do	Decemb	er	31,2011	11:53 A	A.M	
Examin	er			give street and numb S Hospita]		er	4b. City, Town, o	everly	am	P	c. County of Dearince G	eorge's		
Funeral Director		5. Social Security N 220-40-	umber 6		. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 H Hours Mi		ay, Year)		irthplace (State or Fo country) hD.C.	oreign	
ryland I-f show ied at	ctor	Usual Residence of 10a. State D.C.	Decedent 10b. County		10c. Cit	y, Town or Lo	cation ashington					10d. Inside City Li		
rith the Ma 23a or 28e st be notif	Funeral Director	10e. Street and Nur	mber ive St.	,N.E.			10f. Zip Code 200			10g. C	Citizen of What C			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marr 3 [X] Widowed	ried 2 🗌 Marrie	12. Was Deceding Armed Force 1 Yes 2 If Yes, Give	es? ₽ <mark>⊊⊋</mark> No	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🙀 No	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	-	14. Race - Am Black, Wh			
in 72 hours e. nan "natura Medical E	Completed		15. Decedent ecify only highest	Year or Date 's Education t grade completed) College (1-4		(Give life, D	dent's Usual Occup kind of work done O NOT use retired)	during most of w	vorking		Kind of Busines			
be filed with ental Hygien rked other tl ic event, the	To Be Co	11th 17. Father's Name (First, Middle, La	,		Hor	memaker		Name (First, Middle nie Bowi	, Maider	wn Home			
d 2 should alth and M 1 27 is mai er traumat		19a. Informant's Na Deborah				19b. Mailir 847	ng Address (Street 48th St.,	and Number or . N.E. #	er, City o	ty or Town, State, Zip Code) On, D.C. 20019				
Page 1 an nent of He ant: If item iry or othe				3 ☐ Removal from S	tate C	emetery, crer	esition (Name of matory or other place Park		Date 1/2012		Location - City o			
permit. Departr Importa any injt		21. Signature of Fu	neral Service Lic	pensee ///. Q /	att							D.C. 2001	9	
Physician/		23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition	rt fallure. List on (Final	omplications that ca ly one cause on each	used the deat n line.	h. Do not ente	er the mode of dyir	ng, such as card	iac or respiratory a	rrest,	The first	Approximate Interval Betwee Onset and Dear	en	
Medical Examiner		resulting in death)												
uted Id ansit	aminer	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event	nmediate erlying iinjury	Due to (o	consequ	uence of):	nor	rà						
ite be exec hysician ar the burial-t	dical Ex	resulting in death)		Due to (o	as a co ns equ	uence of):	les							
	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months? No		irth 2 Feta ant at time of a	al death 3	Ectopic pregnan Other (specify)	су			23d. Date of delivery Month Day				
ires that the signed by detaction	d by Pr	Part II. Other signif	fice condition	s contributing to dea	ath out not re	in the u	underlying cause gi	ven in Part I.				to the cause of death		
The law requate has beer bage 2 shou	Complete	<u>Pe</u>	rep	hero	//	asc	ula	Des	4a. Was auto perl 1 □ Yes	s an opsy ormed?	prior to	autopsy findings avai o completion of caus ? res 2 \(\sime\) No		
ician: certifica ector, l	Be	25. Was case referrexaminer?	ed to medical	Hospital:				lace of Death (C						
rding Phys th. After this funeral di	cate: To	27. Maprier of Deat 1 Natural Accident		28a. Date of (Month)	ipatient 2 injury , <i>D</i> ay, Yea <i>r</i>)	28b. Time of injury	f 28c. Inju	y at	g Home 5 Res 28d. Describe			∍cify)		
al or Atten s after dea I Director: d in by the	Certificate:	Suicide 4 Homicide	6 Could no	ot be 28e. Place of	Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Numb City or Town, State)					
ne Hospitz in 24 hours ne Funeral pleted fille	Medical	29a. Certifier (Check only one)	Medical Ex	Physician: To the bear aminer: On the basis Nurse Practioner: To	of examinatio	n and/or inves	tigation, in my opini	on, death occurr	ed at the time, date	and place	ce, and due to th	e cause(s) and manne	er stated	
Nithi Note	_	29b. Signature and	title of certifier	En			29c. Licens	e number	8	29d. Date signed (Month, Day, Year)				
2		30. Name and addr	res of person w Cateve	ho completed cause enis, M.D.	of death (Item 3001 H	n 23a) (Type, I Iospita	ol Drive,	Chever	ly,Maryla	and	20785			
Stat Registra		31. Date filed (Mont	th, Day, Year) 5 2012	Geneva 32. Re	gistrarts Signa	Sard								

DHMH 17 Rev 7/2009

Registrar

JAN 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21, 2011 6:15 P. M Mary Sartori December Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Northampton Manor If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 432-18-0785 **Director** 92 1 🗆 M 2 🕱 F Jan 26, 1919 Louisiana 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick ¹X Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 21701 200 E. 16th Street USA er than "natural", or items the Medical Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Maryland 21215-0036 1 Yes 2x No Specify: white Specify. 3 Nidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4 or 5+) Homemaker Own home 2 should be filed with and Mental Hygier 7 is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Elizabeth Caplinger Thomas Reid other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5638 Singletree Drive, Frederick, Maryland permit. Page 1 and 2 sl:
Department of Health ar
Important: If item 27 is
any injury or other trau 21701 John Sartori - grandson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 12-26-2011 Frederick, Maryland Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland ure of Funeral Service Acensee 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ONGESTIVE disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? ☐ Yes 2☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of

Date filed (Month)

GAFFAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED

801

Registrar's Signature

RECAR

DO061410

29d. Date signed (Month. Day, Year)

TOLL HOUSE AVE, FREDERICK, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43332 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ MARJORIE HOLLISTER SIMMONS DECEMBER 07:37 PM 2011 Medical 30 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CECII 119 EAST CECIL AVENUE NORTH EAST 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) FLKTON MARYLAND 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. Security Number Funeral Hours Director 1 🗆 M 💥 213-36-9388 71 09/26/1940 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland notified at Director MARYLAND CECIL 1X Yes 2 No NORTH EAST 10e. Street and Number ms 23a or must be n 0 10f. Zip Code 10g. Citizen of What Country? Funeral 119 EAST CECIL AVENUE UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify Specify "natural" WHITE Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) ll Hygiene. i **other than** " Elementary/Secondary (0-12) College (1-4 or 5+) the ADMINISTRATIVE ASSISTANT EDUCATION Be permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or com-17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ WORTHY HOLLISTER MILDRED BIDDLE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAWRENCE A. SIMMONS / SPOUSE 119 EASR CECIL AVENUE, NORTH EAST, MARYLAND 21901 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State JANUARY 4. cemetery, crematory or other place, 4 Donation 5 Other (Specify) MAYERDALE CREMATORY 2012 NEWARK, DELAWARE 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Rend Onset and Death GanceR Physici_n disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) executed Cause (Disease or injury that initiated events and burial-trai Due to (or as a consequence of) resulting in death) Last attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Dav Year Month 5 Other (specify) Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy page 2 this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner2 Hospital Other: No No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injurv Natural 5 Pending work? М 2 🗌 No Investigation Accident within 24 hours after death To the Funeral Director; 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

of death (Item 23a) (Type, Print)

32. Registrar's Signature

Amend #8 per 19 AACO Health Dep	Y		Type or Pri State of M						-		•),
iro tandi oq	٠	State Registrar	Otate of W	iai yiai i		tificat			ivientai i i	Reg. N	711	43333
		Decedent's Name (First, Middle, Last)					_		2. Date of D	eath		3. Time of Death
Physician Medica	al	Michael I		<u> </u>					Decemi	oer 3	26,2011	4:22 A ^M
Examine	r	4a. Facility Name (if not institution, give st Anne Arundel Medic		. 20		4b. City,		Location of Deat	h		c. County of Dea	
Funeral		5. Social Security Number 6. Sex	7. Ac		ast birthday)	If Unde	r 1 Year	polis If Under 24 Hrs	8. Date of B	irth	Anne aru	rthplace (State or Foreign
Director		220-36-9234	M 2 🗆 F	60	Yrs.	Months	Days	Hours Min.	Nov.	ba <i>y, Y</i> ear)	1951 * 6 51 Mar	vland
ind show	. 1	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	cation						10d. Inside City Limits
Maryla 'Ba-f s stified	rect	Maryland Anne Aru	nde1		Shao	dy Si	ide					1 ☐ Yes 2√ No
h the l	Funeral Director	10e. Street and Number				10f. Zi	Code				Citizen of What C	•
ith wit	ner	1182 Oak Avenue	O Man Danadami	Francia II C	140.1/	Nas Dasa	207		- asif . Van av Nie	1	ited Sta	
er dea or ite	by F.	11. Marital Status 1 ☐ Never Married 2 ☒ Married	2. Was Decedent Armed Forces?		11	f Yes, spe	cify Cuba	spanic Origin? (S n, Mexican, Puerl	o Rican, etc.))-	14. Race - Am Black, Whi	
3030 Jural", JExau	ted	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		1	☐ Yes	2 X No	Specify:			Specify: W	hite
15-(Completed	15. Decedent's Edu (Specify only highest grade					rk done d	ation <i>uri</i> ng most of wo	rking	16b.	Kind of Business	s Industry
212 within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or	5+)				er Drive	er		Truc	king
Ind 21215-0036 Filed within 72 hours after death with the Maryland fall Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	1-b C					18. Mother's Na			,	
ryla uld be d Meni marke	- 1	William Ti		CIDIE					ta Ire			
Baltimore, Maryland 21215-0036 Dermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Mportant: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type Laurie K. Scible /	Wife		100			e, Shady			or Town, State, Z 20764	ip Code)
	1	20a. Method of Disposition		20b. P	lace of Disposemetery, crem	sition (Na	ne of	1	Date		Location - City o	r Town, State
imor Page 1 a ment of B annt. If itu		1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	lemoval from State					ens 12/3	80/2011	Day	vidsonvi	lle, MD
Baltimo permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licenses	10 0		22	. Name ar	nd Addres	is of Facility $ { m J}_{ m C}$	ohn M. 7	aylo	or Funer	al Home, Inc.
	\dashv	23a. Part 1. Enter the disease, or complic	cations that caused	d the death							napolis	, MD 21401 Approximate
- Physician/		shock, or heart failure. List only one Immediate Cause (Final	cause on each line	e.			. 0	Infar	4	211031,		Interval Between Onset and Death
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ords, P.O. Box 68760 requires that the death certificate be been signed by the attending physici should be detached for use as the but	Physician/Medica	IF FEMALE:	Bc. If yes, outcome	of progna	nov.							
OX O	cian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 4 Pregnant a	2 Feta	Ideath 3	Ectopic Other (s)		у		Î	23d. Date of d Month	elivery Day Year
the de by the ached	ž Į	g Unknown	9 Unknown									
P.O.	≥	Part II. Other significant conditions con	tributing to death b	out not resu	ulting in the u	nderlying	cause giv	en in Part I.				o the cause of death?
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an: Th		25. Was case referred to medical					26. Pla	ace of Death (Che	1 🗆 Yes	2 🛂 1	No 1 ☐ Ye	es 2 No
Vita	0	examiner? 1 ☐ Yes 2 🖫 No	ospital: 1 lnpati	ient 2 😿	ER/Outpatien	t 3 🗍 D	Louis			sidence	6 ☐ Other (Spe	cify)
Division of Vital Records, ral or Attending Physician: The law requires s after cleath. al Director: After this certificate has been signed in by the funeral director, page 2 should be	ate:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of inju (Month, Da	iry y, Year)	28b. Time of injury	- [28c. Injury work	?	28d. Describe	how inju	iry occurred	
Siol Attenc r death ctor: y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ury - At ho	me, farm, stre	M eet, factor		Yes 2 No	28f. Location	(Street a	nd Number or Ri	ural Route Number,
Divi		4 - Homiciae - determined	building, etc	c. (Specify))		,		City or To			
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for the difference of the funeral director.	Medical	29a. Certifier 1 ACertifying Physic (Check 2 Medical Examine										tated. cause(s) and manner stated.
o the lithin 2 the loomple!	Ĕ	only one) 3 Certifying Nurse 29b. Signature and title of certifier				leath occu		time, date and pl		the cause		s stated.
FSFÖ		> OVann 5	Surban	, m	3			8563				26,2011
逐人		30. Name and address of person who cor	mpleted cause of d	leath (Item	23a) (Type, P	rint)	0	. 1	(1 -i C	D _{\ /-}	↑ ↑ ∧	aryland
4.2		Wayne Bicrbaum 31. Date filed (Month_Day Year)	00 0	- 1 0:				न्द्रव्य ,	W est h	ive	43 14	4,4,4,6
State Registrar	r	31. Date filed (Month, Day Year) DEC 2 9 20	11 Sen	W.	Ø. 4	back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Certific	ate of	Death			F	Reg. No.		
Physici		Decedent's Name (First, Midd	le,Lest)							2. Date of Dea	ath		3. Time of Death
ledical Exami	ner	Stewart Alex	Stitzel							Month Decembe	er 27, 201	Year 1	1230 hrs
		4a. Facility Name (if not institution	on, give street and r	number)		41	o. City, Town,	or Location	of Death		4c. Co	unty of Dea	ith
		27336 Jenny Hye Lan	ie				Marydel				Card	oline	
√ Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birt	thday)	If Under 1 Ye	ear If Un	der 24Hrs.	8. Date of B	rth (MM/DD/	YYYY) 9. B	irthplace (State or
Director		325-88-2410	1X M 2 F]	9	Yrs.	Months Da	ays Hou	rs Min.	May 2	2, 199	Fore	ountry)I 11inoi s
		Usual Residence of Decedent					<u> </u>		_1	Tray 2	-, 1)	-	"TITINOIS
any.		10a. State 10b. County		10c.	City, Town	or Locatio	n						10d. Inside City Limits
and show	_	Maryland Card	oline		Maryd	le1							1 Yes 2 No
urylar it on	용	10e. Street and Number					10f. Zip Code				10g. Citizen	of What Co	24
e Ma	Director	27336 Jenny 1	Hye Lane				21649				USA	or FFIIdt 00	unity :
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nort of steath and Manal Hygiene; in the Maryland with filem 27 is marked other than "natural", or items 23a or 28a-fabour other traumatic event, the Medical Examiner must be notified at once													
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s afte	Š		orced If Yes, Give Ye or Dates:					lo specif				_{cify:} Whi	
hour fratu	Completed	15. Decedent's Education (Spe			ed) 16a.		s Usual Occup st of working Ii				16b. Kind	of Business	s/Industry
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5-00; led withi Hygiene, I other ti	E	12				une	mploye					ı/a	
Hyge det		17. Father's Name (First, Middle,	•					18.Moth	er's Name (First, Middle,	Maiden Surn	name)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Jack Stewart						Lau	ıra Aı	ın Magı	ırany	Stitz	e1
D 21215-003 should be filed withi and Mental Hygiene. 7 is marked other th	ပု	19a. Informant's Name/Relations		** . 1			Address (Str						
e, MD 2 l and 2 shoul Health and M item 27 is m		Jack Stewart	Stitzel,			2733	6 Jenn	y Hy ϵ	Lane	e, Mary	del,	MD, 2	1649
s la al file file file file file		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal		0b. Place o cremat	of Dispositi ory or othe	on (Name of or place)	emetery,		Date	20c. Loca	tion - City o	or Town, State
Page ent o		4 Donation 5 Other Sa	_			•	Cemet	erv	Dec	31 201	Gre	ensho	ro, MD
Baltimore, MI permit. Pages I and 2. Department of Health a Important: If item 27 injury or other traum		21. Signature of Funeral Service	Lice see	-		22. Na	me and Addre	ss of Facil	ity IC6	W. Sur	set A	ve. G	reensboro
E E P B W	- 3	X Now =	1			lee	gle an	d Hel	fenbe	in Fur	ieral 1	Home	MD 21639
Physician		23e. Part Il Enter the disease, or	complications that	ceused the d	eath. Do no								Approximate Interval
/Medical		failure. List only one cause		o Dia	do-								Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Seizur Due to (or as			_							-
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ed usit	Examiner	events resulting in death) Last	Due to (or as	a consequer	ce of):								
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8760, ificate be up physicials the buri	Š	IF FEMALE: 23b. Was decedent pregnant in th		outcome of birth							23d. Da	te of delive	ry
Box 68 e death certi the attending ed for use as	Ę.	past 12 months?		nant at time			death 3	Ectop	ic pregnan	су	Mon	ith	Day Year
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Division of Vital Records, tal or Attending Physician: The law requires after cleath. al Director: After this certificate has been seen in the funeral director, page 2 should	8	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Ou	utpatient :	3 DOA	Other ₄	Nursing	Home 5	Residence	6 🗸 Othe	er: Scene
I Of ing PI	ا : `	27. Manner of Death	28a. Date	e of Injury h, Day,Year)	28b. 1	Time of Inju	ıry 28c. İnj	ury at Wor	k? 2	8d. Describe	how injury oc	curred	
ath. A	흷	1 X Natural 5 Pend	ing	ii, Day, reai)			1	Yes 2	No				
r Att	ᇐ		tigation 28e. Plac	ce of Injury -	At home, fa	rm, street.	factory, office	building.	etc. 2	8f. Location (Street and N	umber or R	ural Route Number, City
E E B B B B B B B B B B B B B B B B B B	Certification:		not be Specify				7,			or Town, S		ambor 61 11	arai (todio (tambor, oriy
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Division of Vita To the Hospital or Attending Physicil within 24 hours after death. To the Funeral Director: After this co	Medical	(Check only one) 2 ✓ Medical Exar	ysician: To the be niner:On the basis	of examinati	vieuge, dea on and/or ir	itri occurre ivestigation	a at the time, i n, in my opinic	date and p on, death o	iace, and d ccurred at	ue to the caus the time, date	se(s) and ma and place, a	nner as sta ind due to t	ited. he cause(s)
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		30. Name and address of person				000.157	D-W-	C4) - W	MB C15			
	ل	Melissa Brassell, MD	Assistant Me			SUU W.	Baltimore	otreet, E	aitimore	e, MD 2122	23 		
Sta Regist		31. Date filed (Month, Day, Year)		egistrar's Sig	nature	back	11						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 23, 2011 Raymond Stanley Timm 6:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours (Month, Day, Year) 364-18-8061 Director 1 😾 M 2 🗆 F 93 Nov. 28, 1918 MT Usual Residence of Decedent or 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20852 11800 Old Georgetown Road #1441 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify. White 3 Widowed 4 Divorced Specify Completed WWII era 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than ". College (1-4 or 5+) Elementary/Secondary (0-12) Electrical Engineer Engineering and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be fill at of Health and Mental if item 27 is marked Stanley Timm Agnes Kurlinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11800 Old Georgetown Rd., #1441, Rockville, MD 20852 Julia Bryson / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of December 1 XBurial Cremation 3 Removal from State Gate of Heaven Cemetery 27, 2011 4 Donati 5 Qther (Specify) Silver Spring, MD Service License 21. Signature Funera Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 2090 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of Examiner TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No

9 Unknown for Month Day Year 5 Other (specify) Pregnant at time of death q I I Inknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2-25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 7. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1- Natural 5 🗌 Pending work? 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Eng mis

Registrar DHMH 17 Rev 06-2011

State

2+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, MD 10110 Molecular Dr., Rockville, MD 20850

20057124

12123111

Registrar
DHMH 17 Rev 7/2009

20

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nakul Goyal,

31. Date filed (Month, Day, Year)

DEC

29

D38457

Mp, 3801 International Dr., #211, Silver Spring, Md. 20906

Dec. 27, 2011

DHMH 17 Rev 1/2001 OCME 2006

Registrar

31. Date filed (Month, Day, Year)

Registrar's Signat

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43338 State
Registrar Certificate of Death Reg. No. 4 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Registrar 22:40 R Thomas Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 24 Hrs. Hours Min. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 418-56-5817 1 ₹ M 2 □ F Director 71 Alabama Usual Residence of Deced 10/16/1940 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Prince George's Clinton 1 XYes 2 No ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a 9317 Pella Place 20735 United States items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married by 1 X Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) rthan Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha the Supply Supervisor Private event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ <u>Ollie D. Thomas</u> Martha Duff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Pauline L. Thomas/Wife 9317 Pella Place, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans
Cemetery at Cheltenham Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 1-10-2012 Cheltenham, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lice ree 22. Name and Address of Facility Pope Funeral Homes, P.A. M01085 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequent **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant :
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Pregnant at time of death be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 4 No 1 🗌 Yes Yes 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 only one) geriffying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title erti 29d. Date signed (Month, Day, Year) D0055/20 Dec 29 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar MER

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1328 Southern Evenue SE Swite 310 Doshington De 20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day AM HOWAR 1240 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 1790 Addison Rd. District Heights If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**₹**1M 2□ F 61 Director 213-56-3919 Oct 31, 1950 Bryantown MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at PG 17 Yes 2 No Director District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1790 Addison Road S. 20747 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Painter Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Menta Item 27 is marked Roy Thompson Frances Savoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tessa Young/ Sister 1790 Addison Rd. S. District Heights MD 20747 other 1 20b Place of Disposition (Name of emetery, crematory of other 20a. Method of Disposition Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or otl 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 ☐Removal from State verdale MARK 12/30/2011 21. Signature Funeral Sante Licen 22. Name and Address of Facility Tyrone J. Young 5635 Eads Street NE Washington DC 23a. Part1. Ener the disease, or composhock, o heart failure. List only o plications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one case on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (Non Small all **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 ☐ Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA this 5 Residence 6 □Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

31. Date filed (Month, Day, Yea JAN 0 4 2012

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

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29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 24, 2011 Thomas 11:04A M Rose I. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Days Hours Min (Month, Day, Year) **Director** 177-10-3018 97 1 🗆 M 2 🗶 F July 27, 1914 Pennsylvania Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland Clarksburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24425 Peach Tree Road 20871 U.S.A or items 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\subseteq \text{Yes} \) 2 \(\overline{\text{X}} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner 1 Never Married 2 Married 2 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced ed other than "natural", event, the Medical Exa Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer 8 Manufacturing Company is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e James Cowan O'Rourke Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton W. Thomas -P.O. Box 257, Son Clarksburg, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12/29/2011 Lewistown, Pennsylvania 4 Donation 5 Other (Specify) Juniata Memorial Pk. 21. Signatu re of Fun, ral Service Lice 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ T S elevation myocardial infarct disease or condition Minutes Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical as. IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 XNo fo Month Day Year Pregnant at time of death Unknown 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X No certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 \(\text{Yes} 2 XNo Other: ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No I Director: A ed in by the f Accident Investigation Suicide 6 Could not be in 24 hou.. the Funeral Direc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 within 24 ho

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State

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

Yao - Yao Zhu, M.D.

Registrar DHMH 17 Rev 06-2011 M.D

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D53654

9901 Medical Center Drive, Rockville, Maryland

29d. Date signed (Month, Day, Year)

December 24, 2011

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible 13k 1575 yill All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Month Year Jerry R. Thompson 2011 11:35 A Medical December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Manor Care Largo 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 213-56-7967 61 1 XM 2 □ F Maryland Auq. show 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director or 28a-f sl Upper Marlboro 1 Yes 2 No MD Prince George's 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? be ms 23a (must be Funeral 20772 U.S.A. 16110 Mt. Calvert Road "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1X☐ Yes 2 ☐ No Black White etc. Completed by 1 Never Married 2 Married 1X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates Airforce Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental ryggers. I fitem 27 is marked other than "rr other traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Pepco Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Elwood Thompson Mildred Unsworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Thompson/Sister-in-law 16000 Mt. Calvert Rd., Upper Marlboro, MD 20772 20b. Place of Disposition (Name of Department of I-Important: If ite any injury or oth Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 12-27-2011 Baltimore, Maryland Signature of Funeral Service Disensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for all a coner Exami burial-transi and Due to (or as a consequence resulting in death) Last the attending physician ched for use as the buria Physician/Medical alcoholism P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? detached for Year Pregnant at time of death 9 Unknown 9 Unknown n signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director; After the 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifie 00051437 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS RD STE 232 GLENN DALE MD 20769 BITOYE OKEOWO 12200 State

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Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #10a & 19b per FH FCHD IM 1/3 12 State of Maryland / Department of Health and Mental Hygiene . . . , 43342 State Reg. No. Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 29, 2011 2:15 P M William L. Thompson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Monrovia 11942 Fingerboard Road Birthplace (State or Foreign Country) If Under 1 Year I If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days **Director** 220-78-1491 1 XM 2 □ F 50 Feb. 21, 1961 Maryland or 28a-f show a notified at 10d. Inside City Limits 10a. State 10b Count 10c. City, Town or Location Director Maryland Frederick Monrovia 1 Yes 2 X No 10f. Zip Code ^{10e.S}I雪雪型^{um}FIngerboard Road 10a. Citizen of What Country? o pe 23a Completed by Funeral "natural", or items 23 11941 Fingerboard Road 21770 U.S.A. . Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 X Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: If Yes. Give Specify: White 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) 10th College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Theodore Edward Thompson Dolores Burke 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 Fingerboard Road, 21770 Dolores B. Thompson - Mother Monrovia, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Providence Meth. Cem. Jan. 3, 2012 Monrovia, Maryland 21. Signature of Fineral Service Licensee 22 Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ M disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicia. Division of Vital Records, P.O. Box 68760 as the IF FEMALE: asn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown detached for Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? þ ate has been signipage 2 should be 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work?
1 \sum Yes 2 \sum No 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 2 D48184 December 30, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elhamy D. Eskander, M.D. 501 West 7th Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anchorage Nursing Home Salisbury Wicomico Year If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 8. Date of Birth Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Ma^{(Month}, 5^{Day, Y}1917 Months Hours Min. ^{Count}Rnown 1 M 2 X F 240-01-5670 94 Yrs. Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at 72 hours after death with the Maryland Funeral Director MD Salisbury Examiner must be notified Wicomico or 28a-f 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a USA 105 Time Square 21801 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unknown 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. . or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates white "natural" 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unknown unknown Page 1 and 2 should be filed within Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 Progressive Circle, Ste 100, Salisbury, MD 21804 Donna Blackwell p.r. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State Crematory of Delmarva 12/28/11 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. Sign ture of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician/ disease or condition Medical resulting in death) Examiner bo Vac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami the burial-transit that initiated events Due to (o resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director, After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2 ☐ No . Yes 26. Place of Death (Check only one) To Be 25. Was case referred to medical examiner? 2 X No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) work?
1 Yes 2 No 1 Natural injury 5 Pending Accident Suicide Investigation Suicide
Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a MD D 0071972 n who completed cause of death (Item 23a) (Type, Print) 30. Name and add 1415 S. Division State

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G923 1/25/2012 JH
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alfred Turner December 7:15 A.M 30 ,2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 5404 - 21st Avenue Hyattsville 9. Birthplace (State or Foreign Social Security 19924 . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth Month, Day, Year)1924 August 24. **Funeral X** м 2 □ F 87 Hours Virginia 226-28-3924 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No Maryland Prince Georges **Hyattsville** 10e. Street and Number 10g. Citizen of What Country? ò must be Funeral 5404 - 21st Avenue 20782 United States be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc 1 Never Married 2 X Married ò ò Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Chef Adams Hotel 4th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည (unknown) Mary Lou Fred Turner other traumatic ge 1 and 2 should be nt of Health and Mer :: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Elizabeth Lewis Turner |5404 - 21st Avenue; Hyattsville, Maryland 20782 Baltimore, 20c. Location - City or Town, State Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of Jan. cemetery, crematory or other place) ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 0 Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Turner Family Cemetery 2012 Lovingston, Nelson County Signature of Funeral Serv Tame and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ **Urinary Sepsis** weeks disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, Peripheral Vascular_Disease 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed: death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Certificate: To 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: Dethe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur 29d. Date signed (Month, Day, Year) January 4 AC 000937 9200 Basil Court; Suite 200 es of person who completed cause of death (Item 23a) (Type, Print) ANA 20774 Largo, Maryland

Registrar

		Please 1	Type or Print in Blac Amend 26 per DVF State of Maryland / I	ck Indelib R G923 1	le Ink. Ensure /19/12_dk	All Copies	Are Legible.						
		For State Registrar	State of Maryland / I		it of Health and e of Death		ene 2011	43345					
Physicia Medi		1. Decedent's Name (First, Middle, Last) JAMES W. Tho	MAS			2. Date of Death Month	Day 2 Year 2	3. Time of Death					
Exami	ner	4a. Facility Name (if not institution, give st	reet and number)	4b. City,	Town, or Location of Deat		4c. County of Deat	h RUNDE!					
Funeral Director		5. Social Security Number 1 Sex 1 220-74-8417	7. Age (In yrs. last birt.	hday) If Under Months Yrs.	1 Year If Under 24 Hrs Days Hours Min.	8. Date of Birth (Month, Day, You	(ear) Cou	thplace (State or Foreign untry)					
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th the Mi 3a or 28 t be noti		10e. Street and Number		10f. Zip		10	g. Citizen of What Co	untry?					
ath wi	Funeral	3490 OLD CROWN 11. Marital Status	2. Was Decedent Ever in U.S.	13 Was Deced	Z1122 lent of Hispanic Origin? (S	necify Yes or No-	14. Race - Amer	-					
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L	1	Theresa Thomas,	WIFE 34		Eoun De. Pr	SADENA	4D.Z1127	2					
7 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State 20b. Place of cemeter	Disposition (Namey, crematory or o	ne of ther place)	1	oc. Location - City or						
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Balti permit. Departr Importa any inju		4201	M00947		d Address of Facility De	3	MO-ZU						
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Medical Examiner		resulting in death)	Due to (or as a nsequence of										
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ords, P.O. Box 68760 requires that the death certificate be been signed by the attending physic should be detached for use as the b	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnancy				23d. Date of deli						
he dea y the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (sp	ecify)		Month	Day Year					
P.O.		Part II. Other significant conditions cont	ributing to death but not resulting in	n the underlying c	ause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?					
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b.	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fan building, etc. (Specify)	m, street, factory,	office	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,					
e Hospi 24 hou s Funer letely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
To the within To the comp		only one) 3 L Certifying Nurse I	ractitioner: To the best of my know		License number		. Date signed (Month						
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Ctoo		31. Date filed (Month, Day, Year)	32. Registrar's Signature	2 (4)	KN 18m	na r	nonjon	-5					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Derember Flo Mildred VIAR Physician/ 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death
Washington **Examiner** Hagerstown Meritus Medical Center 8. Date of Birth (Month, Day Year) Sept. 23,1917 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Months Days Hours 203-10-7926 Sept. Pennsylvania Director 1 🗆 M 2 🕱 F 94 28a-f shov 10d Inside City Limits 10h. Count 10c. City, Town or Location at 10a. State the Maryland Director ral", or items 23a or 28a-f sl Examiner must be notified Boonsboro Maryland Washington 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code U.S.A. Funeral 21713 permit. Page 1 and 2 should be filed within 72 hours after death with 7611 Fair Play Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Nidowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) her own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leila Fortney Luther M. Mummert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7611 Fair Play Road, Boonsboro, Maryland 21713 Angie Powers - daughter 20a Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State cemetery, crematory or other place)
Cedar Lawn Memaria o = 1 XBurial 2 Cremation 3 Removal from State 5 Department o Important; If any injury or January 13, Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Minnich Funeral Home Signature Funeral Service Licenses 22. Name and Address of Facility Labert 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examir the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death 1 Yes 2 D 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform death? 2 No 1 Yes 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After t 1 Natural injury work?
1 Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director: A Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a

State Registrar 31. Date filed (Month,

TW-7

20311

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) an

MA

trar's Signature

hans Rd Boonsboro 40 2/7/3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec. 26, 2011 Year Physician/ 1600 Vyatkina Valentyna Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth . Age (In vrs. last birthday, Funeral 220-73-4013 Days Hours 8/23/1938 1 🗆 M 2 🔀 F 73 Director Russia ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City. Town or Location Director Montgomery Derwood 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20855 USA Crabbs Branch Way #24 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. marked other than "natural", or 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. þ Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Musatova Ivan Musatov should I and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17709 Shady Mill Road Derwood, Md. 20855 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is n any injury Tatyana Fuksenko/Daughter Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parklawn Mem. Pk. 12/29/2011 Rockville, Md. 4 Donation 5 Other (Spec PHNITE IPADESSRIANALDI FUNERAL SERVICE, P.A. 21. Signature 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Privoiciam Lymphosarcoma disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 Ectopic pregna ō in the past 12 months? Year Month Day t een signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has letely filled in by the funeral director, page 2 s autopsy performed? Yes 2 N 2 🗌 No 1 🗌 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Funeral Director: After this 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1X Natural injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signatu 29c. License number 29d, Date signed (Month, Day, Year) RN43201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd. Rockville, Md. Deborah Miller CRNP 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2 9 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43348 For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ :40PM Ananias Washington 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Summit Park Nursing Home Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Jan 31, 9. Birthplace (State or Foreign . Age (In yrs. last birthday, **Funeral** Months Hours Min 1939 Virginia 225-48-5888 72 Director 1 X M 2 □ F Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 1 Tes 2 X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 21207 USA 5014 Dickey Hill Rd; #A8 Department of Health and Mental Hygiene. In programment of Health and Mental Hygiene. Important: If item 27 is marked others any injury or others. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married ò black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 10 laborer warehouse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)unk ျှ Maggie Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Washington - niece 1510 Mosher St; Baltimore, MD 21217 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD Part 1. Enter the disease, or complicati ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a consequence offcause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial-transii Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Medical Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 10N To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? injury Natural 5 \square Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

NASHING.

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43349 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 22 2011 7:45 A M Wright Robert E1wood Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 6220 Glen Valley Terrace Unit E Frederick 9. Birthplace (State or Foreign Country) District of Columbia 8. Date of Birth (Month, Day, Year) June 9,1936 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 ▼ M 2 □ F 75 577-46-8615 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗓 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6220 Glen Valley Terrace Unit E 21701 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event in the conce. Elementary/Seconday (0-12) College (1-4 or 5+) Technology Owner/Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Lechleider William William Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21701 Lura D. Wright (Spouse) 6220 Glen Valley Terrace Unit E, Frederick, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) December 28, 2011 1 Burial 2 X Cremation 3 X Removal from State Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877 M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MY ELO DY 8 PLASTIC Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day 2 No 1 ☐ Yes 2 L 9 ☐ Unknown q Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ATRIAL FIBRILLATION 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy 1 Yes 2 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ျှ 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manger of Death 28a. Date of injury 28b. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Description Number 1 (1) And the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 3 (76) 29b. Signature and title of certific 5 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOIW, SELBUTH ST. FREDERICK MD 2170 (M. O'CONNER

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 27

40

Registrar's Signature

within 24 hours after death.

To the Funeral Dis-Funeral Director: (Specify) yard Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifi 29c, License number 29d. Date signed (Month, Day, Year) 30 15+1 O.C.M.E. December 21, 2011 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Victor Weedn MD JD Assistant Medical Examiner 31. Date filed (DEC 2) Registrar's Signatu State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 43351 State of Maryland / Department of Health and Mental Hygiene 2 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 рм Timothy Warddell 9:27 William December Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center-Howard County Howard Columbia Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Min (Month, Day, Year) Director 1 ₺ M 2 🗆 F 212-64-6308 56 July 3, 1955 Washington, DC or 28a-f show notified at 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Howard Columbia 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō pe "natural", or items 23a by Funeral 6960 Little Boots USA 21045 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 21215-0036 Specif White 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Letter Carrier US Postal Service Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul L. Warddell Jane W. Crockett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Mary P. Warddell/Wife 6960 Little Boots, Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dec. 30, 4 Donation 5 Other (Specify) of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service L Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring.MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cancer REIVS una disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown detached as been signed by 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy r this certificate has eral director, page 2 perform 1 Yes 2 No a No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospita Other: Haspice 횬 1 Tyes 2 4 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) s after dea... al Director: Aftr injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours a Funeral L Medical 1Va Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 00060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA

State

Registrar

31. Date filed (Month, Day, Year)

2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 30- 2011 Mark Williams 10:27 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Days 244-54-4617 Director 1 XM 2 🗆 F 74 10/19/1937 NC Usual Residence of Deceden or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's District Heights 1 🛚 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or vent, the Medical Examiner must be Funeral 2203 Weber Drive 20747 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fabricator <u>Private</u> Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Dallas Williams Effie Mae Swinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 Weber Drive, District Heights, MD 20747 Esther Williams/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🖳 Removal from State 1-07-2012 Spruill Cemetery Pikeville, NC 4 Donation 5 Other (Specify) Signature of Euneral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sause on each line. Onset and Death consestive Heart Failure Ph sician/ disease or condition Medical resulting in death) Due to (or as consequence of) **Examiner** Acute Atherosciente (Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Cause (Disease or injury that initiated events attending physician and for use as the burial-trai resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown the g 🗌 Unknown be detacl signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 24 hours after death. Funeral Director: After this certificate 2 🗌 No 1 ☐ Yes 2 ☑ No the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No ιê Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of of ifie D 62057

State Registrar

DHMH 17 Rev 06-2011

7-503 SURRATTS ROAD CLINTON MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BANKS

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 29 Month Physician/ 2:15 A M 2011 December <u>Dorothy E. Washington</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Doctors Community Hospital Lanham Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yes Social Security Number **Funeral** 1 □ M 2 🕱 F 82 1929 **Director** 577-32-8932 Jan. Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Upper Marlboro MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 USA 9911 Goldenwood Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 let and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) U S Government <u>Legislative Assistant</u> Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Edna V. Goins Boisy Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or are 13614 New Acadia Lane, Upper Marlboro, MD 20774 Millicent Warren - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation 5 Removal from State Resurrection Cemetery 1/7/2012 Clinton, MD Aure of Fuheral Service Lic. 22. Name and Address of Facility J. K. Johnson Funeral Home, P. A. Temple Hills, MD 20748 6503 Old Branch Ave., Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ock, or heart failure. Lis Onset and Death Immediate Cause (Final Physician/ eta disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, ir any, leading to infimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami burial-trar and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiac Arrhythmia Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed NON-ST-Elevation Myocardial Infarction 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🗌 Yes 2 🗍 No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident
Suicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and lite of certifier 164690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway suite 101A GREENBELL MD 20770

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Washington 2011 16:31 C. Medical Burnie 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery <u> Washington Adventi</u>st Hospital Takoma Park Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral 1 ₺ M 2 🗆 F Days Hours Min (Month, Day, Year) 03/16/1924 Director 23-26-9062 87 Virginia Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No DC <u>Washington</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2107 2nd Street, NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Washington Gas & Elec. should be filed with and Mental Hygien 7 is marked other t 8 Pipe Fitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cornephew Lomax Washington <u>Cary</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr NE Washington, DC 20002 <u>Melvin Jones - Grandson/Son</u> 2107 2nd Street, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 1/14/2012 Brentwood, Maryland 21. Signature of Funeral Service Licenses Ft. Lincoln Funeral Home, Inc. 23a. Part 1. Effer the disease, d'complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the ach line.

Manual Cause (Final) Bladensburg Road Brentwood, MD 20722 Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Six coordiable list over this as Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No **Division of Vital** 25. Was case referred to cal 26. Place of Death (Check only one) Be examiner? 2 🖪 No Other: ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifler Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 . only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JAN 0 5 2012 State

DHMH 17 Rev 7/2009

Registrar

			State	of Ma	aryland	l / Depa	n <mark>delibl</mark> artmen	t of H	lealth	and N	1ental Hy	/gien				
	For State Registrar					Cer	tificate	of E	Death		_	Reg. I	No. 20		4335	
an/ ical	1. Decedent's Nan GEOR		,	VORTE	Н						2. Date of D Month Decemb		^{Day} 2 2	Year 011	3. Time of Death 17:57	
ner	4a. Facility Name (f not institution, g rove Adv			ital	4b. City, Town, or Location of Death Rockville					4c. County of D				Death gomery	
	5. Social Security 1	lumber 6	Sex 1 M 2 □ F	7. Age	(In yrs. las	t birthday) Yrs.	If Under Months	1 Year _ Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	ay, Year	-)	g. Birth Cour	place (State or Foreign htry)	
7	Usual Residence			Ь.,		Town or Lo	cation				March	1/	1931		aryland 10d. Inside City Limits	
Director	MD 10e. Street and Nu	Montg	omery			Ga	ither		g			100	Citizen of W	/hat Cou	1 ☐ Yes 2 🗷 N	
Funeral I		ame Pres	erve Roa	ad			τοι. Ζιρ	Code	208	78		10g.			tates	
þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No 1952— 14. Race - A Black, W Specify: 15 Yes, Give Year or Dates. 1955										k, White,					
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Service 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)												·			
Be Co													/ernment			
To E	William James Whitworth Helen Bealer Whitwor															
	19a. Informant's Name/Relationship (Type, Print) Douglas I. Whitworth / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 200. Mailing Address (Street and Number or Rural Route Number, 200. Mailing Address (Street and Number or Rural Route Nu													Code) 7307		
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	21. Signature of F					22	. Name an	d Addres	ss of Facili	ity Mur		Ва			ral Home d 20882	
	23a. Part 1. Enter shock, or he Immediate Cause disease or condit resulting in death	art failure. List onl (Final on	one cause on e	each line.	e.	Do not ente		of dying	g, such as	cardiac o					Approximate Interval Between Onset and Death	
lical Examiner	if any, leading to i Sause. Enter one Cause (Disease o that initiated even	Sequentially list conditions, if any, leading to immediate bauss. Litter underthing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):														
Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknow	months?		e Birth 2 gnant at	of pregnance 2	death 3	Ectopic p		ey .			å	23d. Date Mor		very Day Year	
þ	Part II. Other sign		,			eting in the u		ause giv	ven in Part	:1,] Yes	2 No	3 ☐ Pro	he cause of death? bably 4 Unknow	
e Completed	25. Was case refer	red to medical			,			26 PI	ace of Dea	ath (Chaci	aut	opsy formęd	? p	rior to co eath?	ompletion of cause of	
te: To Be	examiner?	No th	28a. Dat		y 2	R/Outpatier 8b. Time of injury		1 Oth	er: 4 □ N y at	lursing Ho	ome 5 Res 28d. Describe				y)	
Certificate:	1 A Natural 2 Accident 3 Suicide 4 Homicide	5 Pending Investigat 6 Could no determine	ion t be 28e. Plac	e of Injur		ne, farm, str	M eet, factory	1 🗆	Yes 2	No	28f. Location City or To			r or Rura	il Route Number,	
Medical		Certifying P Medical Exa	miner: On the b	asis of ex	arrination a	and/or inves	tigation, in r	ny opinio	on, death o	occurred at	t the time, date	and pla	ice, and due	to the ca	ause(s) and manner sta	

Registrar

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State

Medical

barks

Rockville, MD 20150

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Orlee Panitch MD 9901 Med

32. Registrar's Signature

Or lee Panitch
31. Date filed (Month, Day, Year)

DEC 27 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 26, 2011 Howlett Wilson 3:23 AM William Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner rince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 579-46-5030 1 □ M 2 T F Director August 3, 1936 Washington, DC 75 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Anne Arundel Maryland 1 🗆 Yes 2 🏋 No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21061 105 Governors Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Auto Industry Auto Body Mechanic should be filed with and Mental Hygien 7 is marked other tl æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Florence K. Folk William B. Wilson traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6309 Davis Blvd. Camp Springs, MD 20746 Department of Health a Important: If item 27 is any injury or other trai Christina Webb - Sister 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 1 Burial 2 Cremation 3 Rem
4 Donation 5 Other (Specify) al from State Edgewater, Maryland 12/27/2011 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. 23a Part 1. Enter the disease, or comp shock, or heart failure. List only o Interval Between Onset and Death Immediate Cause (Final CANCE Indde Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 Yes 2 L the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has io the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate be completely filled in by the fear. certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔽 No 1 🗌 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d, Describe how injury occurred 5 \square Pending 1 🔀 Natural Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Norse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of caftif 29c. License number 29d. Date signed (Month, Day, Year) December 26, 2011

State Registrar 31. Date filed (Mont

strar's Signature

11701 Livingion Rad, Fort WARNING may/ad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. Tiam T. Tawwen un 117cl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2011 Physician/ 10:30A M Lois M. Whitmore December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Gaithersburg 20817 Apollo Lane If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 89 560-28-7080 **Director** 1 □ M 2 🕱 F Nov. 12 1922 Montana Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 No Gaithersburg MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number and Merital Hygiene.
Its marked other than "natural", or items 23a or United States 20882 Funeral 20817 Apollo Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. White Armed Forces?
1 ☐ Yes 2 ☒No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give 3 Midowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Financial Secretary 12 Be filed 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filet. Department of Health and Mental H-Important: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) ပ Unknown Reinhart Edith Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20882 20817 Apollo Lane, Gaithersburg, MD Janet Gregory / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, VA 01/18/12 Arlington National 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Muriel H. Barber Funeral Home Signature of Fuperal Service Lice 0. Box 5038, Laytonsville, MD 20882 low 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimers Ph_sician/ Pars disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed and -trar Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. hear 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has perform To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate has been breed to be turned director, page completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 1 Nursing Home 5 Aesidence 6 \(\text{Other} \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Certificate: injury 5 Pending 1 Natural work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature a d title of certifier 29c. License number 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) 10 Russel Me OVA

State Registrar 31. Date filed (Month, Da

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Linda Lee Johnson Watkins 6:54 PM necembe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Hospital Center Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 946 Months Hours July 31, 65 **Director** 213-46-8261 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Maryland Director 10d. Inside City Limits notified 1 Yes 2 X No Maryland Washington Hagerstown 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral Page 1 and 2 should be filed within 72 hours after death with 13258 Onyx Drive 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White 3 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Owner/Operator Beauty Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Guy Johnson Virginia Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald R. Watkins, Sr.- Husband 13258 Onyx Drive, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) . of F. 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important; If any injury or 4 Conation 5 X Other (Specify) Entombment Olivet Mausoleum 1/05/2012 Mt. Frederick, Marvland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland Sign ture of uneral Service Sensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final epilepticus STATUS Ph sician/ metaisolic disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) signed by the attending d be detached for use 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes 2 ₺ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by Mellins 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Kidney 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 Yes Yes 2 Wo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Division of Vital Records, P.O. Box 68760 24 hours after death.

Funeral Director: After this certificate has the Hospital or Attending Physician; The completed filled in by the within 2 To the F

> 6 State Registrar

29a. Certifier

29b. Signature and title of certifier

NCI SCO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEU

32. Registrar's Signature

Do

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ mes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbour Health & Rehab <u>Annapolis</u> Anne Arunde1 Social Security Number If Under Hours 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months 200-16-4558 Director 1 🛮 M 2 🗆 F New York 88 11/05/1923 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2640 Compass Drive 21401 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give WWII
Year or Dates. Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify 3 Divorced 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Sales House Wares 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Charles Walzer Regina Wacker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Walzer Spouse 2640 Compass Drive Annapolis, MD 21401 Important: If item 27 any injury or other tra Baltimore, Method of Disposition

Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Veterans Cemetery Page 1 o 01/03/2012 Crownsville,MD 4 Donation 5 Other (Specify) 21. Signature o Furferal Service Licens 22. Name and Address of Facility Hardesty Funeral Home P.A. Annapolis, MD 21401 all Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: ျပ 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CELONY MAHBOOB 31. Date filed State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ HITE MAN 6:30 PM ONALD Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Anne Arundel 931 Edgewood Road Apt 108 Annapolis Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours Min 336-30-5741 74 Director 1 **K** M 2 □ F 5/21/1937 New Jersey Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location must be notified at Director Maryland Anne Arundel Annapolis 1 🗷 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral USA 21403 931 Edgewood Road Apt 108 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 No
If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner Black, White, etc. 9 þ 1 X Never Married 2 Married 1 Yes 2 No Specify: Specify: 60-62 White "natural" Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lab Assistant Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even ပ Norma Victoria Frank Russell Albert Whiteman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1008 York Lane, Annapolis, MD 21403 Marilyn K. Clark - POA 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2x Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Crematory 12/29/2011 Baltimore, MD 21. Signature of Funeral Service Licensee

Myclin T. Wolver 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Hospital or Attending Physician: The Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 L NO 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. neral Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 🗌 Yes 2 🗆 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

"JAN 11"3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygie	ne	10001
			1109.04.01	ertificate of Death	Reg.	. No. 2011	43361
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Orville R. Watkins		2. Date of Death Month	^{Day} 1, 2011	3. Time of Death 12:44 P M
	Medic Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	December	4c. County of Death	
	LAGIIII		125 Queen Anne Bridge Road	Upper Marlboro		,	George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	g, Birth	nplace (State or Foreign
jele	Director		214–36–1657 Usual Residence of Decedent 1 ♀ M 2 □ F 72 Yrs.		3/5/1939		land
	show dat	ξ	10a. State 10b. County 10c. City, Town or Le	ocation			10d. Inside City Limits
	Mary 28a-f otifie	irec	MD Prince George's Upper Mar	:lboro			1 ☐ Yes 2X☐ No
	ith the 3a or t be r	ralD	10e. Street and Number	10f. Zip Code	"	. Citizen of What Cou	untry?
	ems 2	Funeral Director	125 Queen Anne Bridge Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20774 Was Decedent of Hispanic Origin? (Spe		JSA 14. Race - Ameri	ican Indian.
ထွ	ter de , or it	by	1 Never Married 2 Married 1 Vac 2 XIVa	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	Rican, etc.)	Black, White	, etc.
8	ours a tural" al Exa	Completed	3 - Widowed 4 E-Divorced Year or Dates.			Specify: Amer	rican
5	72 hd in "na Medic	mple	(Specify only highest grade completed) (Give	edent's Usual Occupation • kind of work done during most of work DO NOT use retired)	ing 16t	b. Kind of Business/li	ndustry
212	within giene. er the		Elementary/Secondary (U-12) College (1-4 or 5+)	Equipment Operato	or To	ownship of	Bowie
nd	e filed Ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	len Sumame)	
<u>S</u>	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	-	Harry B. Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Cora Wat			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		102.1114	ing Address (Street and Number or Rure) Gittings Ave., I	Baltimore, City		
ore,	of Hear of Hear fitem		20a. Method of Disposition 20b. Place of Disposition	osition (Name of ematory or other place)	Date 200	c. Location - City or T	Town, State
Ĕ	Page ment tant: I		Danial Z - Olemation o - Helioval Ioni otate	Mem. Gardens 1/7,	/2012 [Davidsonvi	lle, MD
Bai	permit Depart Impor any in				all Funera		
		_	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent	6512 NW Crain Hwy,		Maryland,	20715 Approximate
, interest	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	5 Disease			Interval Between Onset and Death
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	· 1 1 0001			15 Yrs.
	Examiner	Je.	ocquoritiany not containone;	hal Olle.			6 monty;
	ed .	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or Injury				
	be executed sician and burial-transi	Exa	that Initiated events resulting in death) Last C. Due to (or as a consequence of):				
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о В	the de by the tachec	Physician/Me	g Unknown				
ў.	law requires that the death certifica nas been signed by the attending pf e 2 should be detached for use as t	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to t	
rds	equire	eted					obably 4 Unknown
Vital Records,	e law r e has b ge 2 s	Completed			24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
r m	an: Th tificate tor, pa	Be Co	25. Was case referred to medical	26, Place of Death (Check	1 Yes 2	No 1 ☐ Yes	2 No
Ĭ	nysicia nis cer I direc	To B	examiner? 1 Yes 2 No Hospital:	Tother		e 6 Other (Specif	(y)
וסו	ing Pl		27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time o injury	work?	28d. Describe how in	ijury occurred	
SIO	Attend death ctor; /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	28f Location (Street	and Number or Rura	al Route Number
DIVISION	al or A s after I Dire ed in b		4 Homicide determined 28e. Place of injury - At nome, farm, str building, etc. (Specify)	cot, ractory, critics	City or Town, St.		arnoate Namber,
	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or invest	occurred at the time, date and place, ar	nd due to the cause(s	s) and manner as sta	ited.
	the tithin 2 the E	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	e, death occurred at the time, date and pla	ace, and due to the ca	use(s) and manner as	stated.
	20		Julian Jamah Mala Mala	20058213	290.	1/2/12	ωω, reω/
	9		30. Name and address of person who completed cause of death (Item 23a) (Type,	29c. License number 20058213 Print) A mapolis	RI Ch	emDal	e MD zaze
			FARHAD JAMACI MD 121	50 Nungune	16 00		- 20/07
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 32. Begistrar's Signature 32. Begistrar's Signature	back			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 3 per med cert G923 1/19/12 dk.
State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:15 PM December 2011 Elaine Williams 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Havre de Grace If Under 1 Year | If Under 24 Hrs. Harkord 1107 Revolution Street 8. Date of Birth (Month, Day, Year) 08-17-1926 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Mary Land Hours 220-22-0120 1 □ M 2 👿 F 85 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, it e Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director Haure de Grace Harrond 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 1107 Revolution Street 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2 🛮 No Specify: <u>≽</u> 3 ☑ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Service Elementary/Sperondary (0-12) College (1-4or 5+) Secretary permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglent Important: If item 27 is marked other tha any injury or other traumatic event, If an one. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilhelmina Debelius Allen Walter Kirtscher. Sr. ပ 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 318 Brady Lane, Middletown, Delaware 19709 Patricia Perrone (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State Angel Hill Cemetery |12-16-2011 |Havre de Grace Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Si 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mercice 'ell Carcinoma Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a conse Mence of Examiner If a y, leading to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed and Due to (or as a consequence of) burial attending physician for use as the burla Box 68760. Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 8 page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No Hospital or Attending Physician: The certificate 1 ☐Yes 2 ☐No Division of Vital this certific at director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Certification: 5 Pending investigation ithin 24 hours after death.

b the Funeral Director: Aft
ompletely filled in by the fun 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 Name and oddress of person who completed cause of death (Item 23a) (Type, Print) 2 5 32. Redistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Items Registrar	28a-i per me, g92	Depai Cert	rtreptof2 ificate of L	lealth and Death	Mental Hyg R	iene _{eg. No.} 201	1 43363			
	Physicia	in/	1. Decedent's Name (First, Middle, Lat	·				2. Date of Deat Month	Day Year	3. Time of Death			
Jan 16	Medic	cal	James Calvin V 4a. Facility Name (if not institution, give			4b. City Town or	r Location of Deat		02 2011 4c. County of De	M			
	Examir	ier	Genesis Homewo			Baltime			N/A				
	Funeral Director		213-00-1023	ex 7. Age (In yrs. last bit		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, 03 31	th y, Year) 9. Birthplace (State or Foreign Country) MD				
	ind show at	៤	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Loca	ation		<u> </u>	-	10d. Inside City Limits			
	Maryla 28a-f s	rect	MD N/A	Baltir	nore					1 🎛 Yes 2 □ No			
	s 23a or 2	Funeral Director	10e. Street and Number 1027 Radnor Ave			10f. Zip Code 212	12	1	0g. Citizen of What 0	Country?			
9036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates.	If \	as Decedent of H Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify:B1				
Maryland 21215-0036	ed within 72 hou Hygiene. other than "natent, the Medica	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12) 9th	College (1.4 or 5.)	(Give kir life. DO	nt's Usual Occup nd of work done o NOT use retired) Man	ation during most of wo	rking	16b. Kind of Busines Cockeys Removal	,			
yland	should be filed and Mental Hygelis marked others and marked others and and the seconts.	To Be	17. Father's Name (First, Middle, Last) Calvin C. Will	iams Sr.				^{me (First, Middle, N} Carter	flaiden Surname)				
	시문화를	Ÿ	19a. Informant's Name/Relationship (7 Michelle Willi	,, ,	-				City or Town, State, 2				
Baltimore,	Page 1 nent of ant: If it		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🗀 Other (Speci	Removal from Statecemete	erv. crema	tion (Name of atory or other place Cemt.	:e) 10/8	- 1	20c.Location-City o				
Balt	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licens	K. Imed	22. I A V (Name and Addres	ss of Facility Ma	arch F/I MD 2120	H 1101 E	. North			
	Ph, sician/ Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart fallure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	Tic		g, such as cardiac		to Fall	Approximate Interval Between Onset and Death			
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200	physici the bu	edical		d		10	CERTIFICATIO	f.tv.					
. Box 667	ath certif attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown		Ectopic pregnand Other (specify)	ey		23d. Date of o	delivery Day Year			
Division of Vital Records, P.O.	requires that the der been signed by the s should be detached	ğ	Part II. Other significant conditions of	ontributing to death but not resulting	in the und	derlying cause giv	ven in Part I.			to the cause of death? Probably 4 Unknown			
Recor	The law recate has be page 2 shd	Completed						24a. Was ar autops perforr 1 \(\sum \) Yes	prior to med? prior to death?	autopsy findings available o completion of cause of es 2 140			
ital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examine?	Hospital:	-	Othe	ace of Death (Che						
of V	iding Phys th. After this funeral dii	te: To	27. Manner of Death		Time of	3 L DOA 28c, Injury	4 Nursing F		nce 6 Other (Spe w injury occurred	ecify)			
on	eath. or: Aft the fur	fical	1 Natural 5 Pending 2 Accident Investigation	03/24/2011 9:	injury :15a	M work	? Yes 2□No	Subject	fell off	trash truck			
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the fune.	al Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify) Roadway	arm, stree	t, factory, office		28f. Location (Str City or Town Baltimo	reet and Number or F , State l 539 Bu re, MD	Rural Route Number, ISh Street			
1	e Hosp 124 hor e Funer reted fin	Medical	(Check 2 Medical Exami	sician: To the best of my knowledge, iner: On the basis of examination and/	or investig	ation, in my opinio	n, death occurred	at the time, date and	d place, and due to the	e cause(s) and manner stated.			
	To the within To the comp	2	29b. Signature and title of certifier	m.D.	,	29c. License			9d. Date signed (Mor				
				completed cause of death (Item 23a)	(Type, Prin	te 2a	1. Pa	rcuil	1,70	21254			
-11	Stat Registra		31. Date file (Month, Day, Year) JAN 1 3	2012 Signature	9. 4	barkel)						

			amend #9,11,12,15,16a,17,	Black Indelible Ink, Ensi 8 & 19a&b Per ANA BD d / Department of Health a	ire All Copies.	Are Legible.					
		-	For State Registrar	Certificate of Death		eg. No. 2011 43364					
	Physicia	n/	Decedent's Name (First, Middle, Last)		2. Date of Death Month						
shiring	Medic	al	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	111	Q ^{Day} 2 ^{Vear} 2336 M					
	Examir	er	HOLY CROSS HOSPIT		RING	MONTGOMERY					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia	st birthday) If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Birth Min. (Month, Day,	9. Birthplace (State or Foreign Country)					
	Director		S76-70-8968 1 № 2□F 56	Yrs.	07,25,	1953 South Carolina					
	yland f shov	ctor		, Town or Location		10d. Inside City Limits					
	or 28a- notifi	Dire	MD MONTGOMERY SI) 10e. Street and Number	_VER SPRING		1 ☑ Yes 2 ☐ No					
	with the 23a cust be	Funeral Director	2700 BARKER ST	20910	["	USA					
	death items ner m	Fun	11. Marital Status 12. Was Decedent Ever in U.S	1,1	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.					
36	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:		Specify: Black Class					
21215-0036	hours maturi dical E	olete	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation unk (Give kind of work done during most	of working	16b. Kind of Business/Industry unk					
121	thin 72 ane. than the	om	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NOT use retired)	or working						
	filed within al Hygiene.	Be C	unk 12 0 unk 17. Father's Name (First, Middle, Last) unk	Secruity Guard	's Name (First, Middle, Ma	aiden Surname) unla					
Maryland	uld be file Mental narked c	욘	John W. Young		y Louise Co						
Man	should and Me 7 is mar raumati		19a. Informatic Name (Fylationship Tsi Sitter	19b2001 AMress PtreNEnd Appes							
	and 2 s Health tem 27		20a. Method of Disposition 20b. Pl	ace of Disposition (Name of	<u> </u>	20c. Location - City or Town, State					
Baltimore,	1 4 1			emetery, crematory or other place)	Date	coc. Education - Oily of Town, State					
alti	permit. Page Department Important: I any injury o once.	1	21. Signature Francial Service Licensia	22. Name and Address of Facility	State Anato	my Board					
<u>m</u>	9 9 E E 9		KINIVII WILL	655 W. Baltimore St; Baltimore, MD 212							
			23a. Part 1 Enter the disease, or complications that caused the death shock, of heart failure. List only one cause on each line. Immediate Cause (Final			Interval Between					
	Physician/ Medical		disease or condition resulting in death) Due to (or as a consequence)	ONOF CONGESTIVE	HEART F	ALLINE UNK					
(7)	Examiner		Sequentially list conditions, b.								
	sit sit	Examiner	cause. Enter Underlying	stice of):							
	executed an and rial-transi		Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence)	ence of):							
8		lical	d								
Box 68760	intification of the second of	_	IF FEMALE:								
) XO	ath ce attend I for us	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of december 2.	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year					
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P.O.	Attending Physician: The law requires that the death certificate be ri death. If death are this certificate has been signed by the attending physicicator. After this certificate has been signed by the attending physicic by the funeral director, page 2 should be detached for use as the bit.		Part II. Other significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing the significant conditions contributing to death but not result in the significant conditions contributing the significant conditions conditions contributing the significant conditions contributing conditions conditions conditions conditions conditions conditions conditions conditions conditions	Iting in the underlying cause given in Part I.		acco use contribute to the cause of death? s 2 \(\sum \) No 3 \(\sum \) Probably 4 \(\sum \) Unknown					
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ecc	The law ate has page 2	omp	MORBID OBESITY HYPERTENSION		autopsy perform	prior to completion of cause of death?					
al F	ician: The certificate rector, pag		25. Was case referred to medical examiner?	26. Place of Death	1 Ves 2 (Check only one)	▼No 1 ☐ Yes 2 ☐ No					
Ξ	Physic this ce al dire	유	1 ☐ Yes 2 ☐ No Hospital.		sing Home 5 Residen	nce 6 Other (Specify)					
n o	ding F th. After t funer	cate:	1 Natural 5 Pending (Month, Day, Year)	28b. Time of injury at work? M 1 Yes 2 1	28d. Describe how	v injury occurred					
Division	al or Attendin s after death. I Director: Afte d in by the fur	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At hor	ne, farm, street, factory, office	28f, Location (Stre	eet and Number or Rural Route Number,					
<u>≤</u> .	Hospital or 24 hours afte Funeral Directely filled in		building, etc. (Specify)		City or Town,	State)					
	To the Hospital or within 24 hours after To the Funeral Directory of the Completely filled in the	Medical	29a. Certifier (Check 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination	and/or investigation, in my opinion, death occ	urred at the time, date and	place, and due to the cause(s) and manner stated.					
	To the within To the Compl		only one) 3 Certifying Nurse Practitioner: To the best of m 29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)					
			· Chowdy	1 10431	21	11,09,11					
			30. Name and address of person who completed cause of death (Item	/ .	MINORI &	10 30404					
	Stat	e	NURUL CHOWDHURY, MS. 31. Date filed (Month, Day, Year) 32. Registrar's Signature of the state of	605 MAIN ST L	MUKEL 1	1D 20707					
	Registra		IAN 1 9 2012 /2 mm &	. gave							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Stephan Wasyl Atanasov December 2011 8:28 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Hours Days Director 212-76-8993 1 XM 2 □ F 54 Dec. 17, 1957 Pennsylvania Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City. Town or Location Director be notified 28a-f 1 Yes 2 X No Maryland Frederick Middletown 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a c must be Funeral 4303 Mica Court 21769 U.S.A. items Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican. etc. Black, White, etc. by 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Construction Superintendant Be Baltimore, Maryland 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wasy1 Stephan Atanasov Elenka Ninova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vickie J. Atanasov - Wife Department of Health Important: If item 27 any injury or other the once. 4303 Mica Court, Middletown, Maryland 21769 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Olivet Cemetery Jan. 7, 2012 Frederick, Marvland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 21. Signature of Nineral Service Lisensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Due to (or s a p nsequence of) CUNCEY disease or condition Medical resulting in death) **Examiner** lobucco USE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exam burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Id be detached for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? obstructive pulmonary 1 X Yes 2 No 3 Probably 4 Unknown this certificate has been signal director, page 2 should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 🗌 Yes 2 🗌 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 XYes 2 No Hospital: Other: ည 1 Inpatient 2 XER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier MD

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lowery

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31. Date filed (Month, Day, Year)

Partura Medical

32. Registrar's Signature

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01-03-2013

Frederick, MD

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Medica Examine	_	4a. Facility Name (if not institution FREDERICK MEN				4b. City, Town, c		of Death	DECEM	4c	County of E FREDER	eath	1.671	
Funeral Director		5. Social Security Number 206-34-0254	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. 68	last birthday) Yrs.	If Under 1 Year Months Days	Jf Under Hours	Min.	8. Date of Bir (Month, Da March	th y, Year) I , I	943 P		ce (State or i	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	irector	Usual Residence of Decedent 10a. State 10b. County	erick	ļ.	ty, Town or Lo	cation				10° Ci	itizen of What		d. Inside City	
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d 2 shoul alth and 1 1 27 is ma er trauma		19a. Informant's Name/Relations Michael Arterbu		nd		ng Address <i>(Street</i> Amys Ter								
Page 1 and nent of Hea ant: If item ary or othe	- 1	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (\$	3 Removal from	20b.	cemetery, cren	sition (Name of natory or other pla Cremato			Date /30/11	l	ocation - City			
permit. Departn Imports any inju		21. Signature of Juneral Service 1	ticensee ,			Name and Addre tauffer 621 Opos				A. eder	rick,Ma	ary1	and 21	1702
Physician/ Medical		23a. art 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on ea		04	er the mode of dyi	ng, such as	cardiac d	or respiratory a	rrest,		_ ~l	Approximate nterval Betwo Onset and De	een eath
Examiner	. l	Sequentially list conditions,	b &C	or as a conseq	13 600	trial pe	mon	tis				2	days	
× - 0	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or limitary that initiated events resulting in death) Last	c. Due to	(or as a conseq	usalve,on:	rods &	ecter	emi	a			1	day	
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v requires that the de been signed by the should be detached	ed by Pr	Part II. Other significant condition		eath but not re	sulting in the u	inderlying cause g	iven in Part	l.	23e. Did 1		use contribut		cause of dea	
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tending Fleath. or. After the funer	Certificate:	27. Manner of Death 1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	gation	of injury th, Day, Year)	28b. Time of injury	wor		- 1	28d. Describe	how inju	ry occurred			
To the Hospital or Attending I within 24 hours after death. To the Funeral Director After completed filled in by the funeral Macinal Cartificates		4 Homicide determ	nined 28e. Place buildi	ng, etc. (Specif	(5y) 	eet, factory, office			28f. Location (City or To	wn, State	e) 		oute Numbe	r,
the Hosp hin 24 ho the Fune npleted f	Medical	(Check 2 Medical in only one) 3 Certifying	Physician: To the be examiner: On the bas Nurse Practioner:	sis of examination	on and/or invest	tigation, in my opin death occurred at t	ion, death o	ccurred a	t the time, date	and place ne cause(e, and due to (s) and manne	the caus r as stat	ed.	ner stated.
To writ		29b. Signature and title of certifie	Navius	1. Nefler	imD	29c. Licens	e number 2977	7		29d. Da	ate signed (M 2/25/	onth, Da	//	
5		30. Name and address of person	who completed caus	se of death (Iter	m 23a) (Type, F	Print)	1 NJ	1.	Stree	11 -		_	12 000	201
State Registrar	'	31. Date filed (Month, Day, Year)	2012 32/2	egistrar's Signa	ature 40	arked	T 17	√\	31760	کر ا	red	enic	IN WI	77

DHMH 17 Rev 7/2009

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DHMH 17 Rev 1/2001

OCME 2006

Registrar

Zabiullah Ali, M.D. 31. Date filed (Month, Day Year)

32 Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43368 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1432 Dec. 2011 Tsedeke Alemayehu Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 7600 Maple Ave. #1009 8. Date of Birth
(Month, Day Year) Takoma Park Montgomery 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months 1 XM 2 - F Hours 219-67-9444 61 1950 Ethiopia **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No MD Takoma Park Montgomery 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a United States 7600 Maple Avenue #1009 20912 "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Courtesy Officer Commercial Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Taye Alemayehu Kijinesh Gemaneh other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9700 Merwood Lane, Silver Spring, MD 20901 <u>Christian Taye/Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ö 1 ☐ Burial 2 ☐ Cremation 3 🛣 Removal from State injury Holy Trinity Church | Jan 6, 2012 Addis Ababa, Ethiopia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington,DC 20012 23a. Raft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) EROSCIEROTIC CORONARY HEART DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impry that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial traces. Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ In the past 12 months? Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗌 No ၉ 1 ☐ Inpatient 2 ☐ ER/Cutpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗀 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicīde 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature ar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2011 December 8:15 AM Neli Ambrogi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Hebrew Home of Greater Washington 9. Birthplace (State or Foreign Country) Italy 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** March Day Hours Min. 1 D M 2 D 215-38-3035 88 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2x No Maryland Montgomery Kensington 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code Funeral 20895 3703 Calvert Place Italy 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Adriano Sodini Giustina Cottini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silwen Lane, Norwalk, CT 06851 Esterina Consolati / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery31, 2011 20a Method of Disposition 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funcral Service Lines 22. Name and Address of Facility Francis J. Collins Funeral Home, 500 University Blvd., W., Silver Inc. Spring, MD 2090. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final AS CULAR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examine Se wentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 200 Division of Vital Records, 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 X No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mapner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INESH

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43370 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 5:06 A.M Byrne December Joseph Leo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Calvert Memorial Hopsital Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday **Funeral** Hours 1 🗶 M 2 🗆 F 02/06/1922 Washington, 89 Director 577-24-4725 Usual Residence of Decedent 23a or 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No MD Chesapeake Beach Calvert 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 7836 C 20732 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Divorced Completed Year or Dates. WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Navy 12 recruiter irmit. Page 1 and 2 should be filed wit spartment of Health and Mental Hygies portant: If item 27 is marked other in y injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Bernard Byrne Eileen Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5300 King Charles Way, Bethesda, MD Mary Goldman, niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Remerval from State 01/03/2012 Washington, DC 4 Donation 5 Other (Specify) Olivet Cemetery 21. Si palue of Funeral Service Licer 22. Name and Address of Facility Rausch Funeral Home, Lane, Owings, MD 20736 8325 Mt. Harmony 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ CUTT MYOC Medical resulting in death) Due to (or as a consequence of) Examiner ORUNART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA the Funeral Director: After that pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural work 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 6373 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEIGE

State Registrar 31. Date flied (Month, Day, Year)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Bean Blandford 7:30 A M Margaret Dec Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Prince George's 13902 Cherry Tree Crossing Road Brandywine Social Security Number If Under 24 Hrs. g. Birthplace (State or Foreign . Age (In vrs. last birthday 8. Date of Birth Date of Day, (Month, Day, **Funeral** 1 🗆 M 2 💢 F Hours 218-42-3117 99 Maryland Director Feb ľ 912 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be r Funeral USA 13902 Cherry Tree Crossing Road 20613 ral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. "natural", Specify: Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working alth and Mental Hygiene. n 27 is marked other than "! er traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Alexander Bean Marian Early 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13902 Cherry Tree Crossing Rd, Brandywine, MD 20613 Roland B. Blandford - Son Department of Health Important: If item 2 any injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ¹XX Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. St. Mary's Piscataway 4 ☐ Donation 5 ☐ Other (Specify) 2011 <u>Clinton, Maryland</u> Ergler 22. Name and Address of Facility 22. Name and Address of Facility Lee Funeral 8200 Jennifer Lane, Owings, I l Home Calvert, P.A. MD 20736 manda M m a unlications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrestly one cause on each line. . Part 1. Enter the disease, or coolication shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ate has been signed by the atte page 2 should be detached for in the past 12 months?
1 Yes 2 No Month Day Year g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? this certificate 2 🗌 No 1 Tyes al or Attending Physician: The safter death.

In Director: After this certifical соmpleted filled in by the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Kesidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, de eath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

JRW 4

State Registrar 31. Date filed (Month, Day,

Registrar

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

INE CENTER WHIMF, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. Day Broome Pamela 2011 21 A^{M} 2:44 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Port Republic 4c. County of Death Calvert **Examiner** 3255 Hance Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Octoor | Control of the second secon 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Country) MD 0 c/Month 203y, Yell 1963 1 ☐ M 21 F 219-02-0374 48 Director Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Port Republic 1 🗆 Yes 2 🗖 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3255 Hance Road Funeral 20676 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 0. 1 ☐ Yes 2 🗓 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: Page 1 and 2 should be filed within 72 hours aft nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", 3 Divorced 4 Divorced Year or Dates 15, Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Caregiver Private Duty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Gantt Eliza Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Broome, Jr./son 21280 Lexwood Ct. Apt.2A LexingtonPark, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Brooks UMC Cem. 1 D Burial 2 Cremation 3 Removal from State 12/29/2011 St. Leonard, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySewell Funeral Home, Glady 1451 Dares Beach Rd. Prince Fred., MD20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 10 CCC CI disease or condition resulting in death) ang Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed?
Yes 2 No page 2 Hospital or Attending Physician: The 124 hours after death.
Funeral Director, After this certificate hated filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛪 No 26. Place of Death (Check only one Be mo vers nac Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify Hospital 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be To the Hospital or Atter within 24 hours after de: To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🏋 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination add/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW 0 MAN 32. Registra s Signature State Registrar

Box 68760

P.O.

Division of Vital

VOID

CERTIFICATE

2011-43373

SEE

CERTIFICATE

2012-0340

completed 2/10/2012 W8.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) DEC 29 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 43375 State of Maryland / Department of Health and Mental Hygiene 2 U 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Geraldine 20¹1 Lewis Beegle 3:45 A M December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Allegany 4b. City, Town, or Location of Death Examiner 512 Schlund Avenue Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 👿 F Ohio Country) 213-24-5743 83 0274971928 Director Usual Residence of Decedent or 28a-f show notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 □ No ms 23a or must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 512 Schlund Avenue 21502 USA ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the College Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 1 and 2 should be fill of Health and Mental fitem 27 is marked o 2 Weber Warren Geary Lewis Rose Elizabeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 512 Schlund Avenue, Cumberland, MD John E. Beegle / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, Date 1 X Burial 2 Cremation 3 Removal from State Hillcrest Mem. Park 12/20/2011 4 Donation 5 Other (Specify) Cumberland, MD . Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part In er the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, Theart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition own Medical resulting in death) Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Yes 2 No ed by the a g 🗌 Unknown P.0. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate | 2 🗆 No 2 No 1 Tyes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 🗶 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide Hospital or Attending 5 Pending Division thin 24 hours after death the Funeral Director: A mpleted filled in by the fi 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 29c. License number December 19, 2011 D0066150 ev. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Muhammad Naeem, M.D., 625 Kent Avenue, Cumberland, Maryland 21502 31. Date filed (Month, Day, Year) 32, Registrar's Signature State 19

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 30, 2011 Physician 2056 P M Charles Ball Norman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cecil 82 Elk Chase Drive Elkton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/24/1922 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 328-18-4167 Director Kansas Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e.4.4.4. any injury or other traumatic event, Its Margaret any injury or other traumatic event, Its Margaret any injury or other traumatic event, Its Margaret any injury or other traumatic event, Its Margaret and Its 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Cecil Elkton 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 USA 82 Elk Chase Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Mayes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐Yes 2X No ģ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Exposition Decorating Elementary/Secondary (0-12) 12 College (1-4or 5+) Service Decorator 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Norman Ball Beulah Warren ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Kordik / daughter 118 Peace Court East, Bear, DE 19701 20b. Place of Disposition (Name of cemetery, crematory or other place Deltona Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 01/05/2012 Orange City, FL 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Family Funeral Home 635 Churchmans Road, Newark DE 19702 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or compiledions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) bocordia /Medical Due to wir as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day is certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate 2 **X**No 1 ☐ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1XYes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

> State Registrar

DHMH 17 Rev 1/2001

JAN 03 2012

Myers

29b. Signature and title of certifier

Andrew

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

ORIGINAL

29c. License number

1941 Limestone Rd, Suite 107, Wilmington

C10005990

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month December Physician/ 2011 1:02 A M FREDERICK BAKER RAYMOND Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Days Hours Country 12/09/1939 PA Director 196-30-8797 Usual Residence of Deceden ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21716 114 E. H Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify Specify. 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72., h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) National Park Service writer/editor 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Kathryn Berkey Earl Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and.
Department of Healt.
Important: If item 27
any injury. 27 114 E. H Street, Brunswick, MD 21716 Barbara Baker/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/02/2012 Frederick, MD Stauffer Crematory 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ atherscherosis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as the use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year be detached the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? diabete. Yes 2 No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 KER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred e Hospital or Attending Pi 124 hours after death. e Funeral Director, After ti 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certific 2 Educal MD 056890 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) th Avenue Ssurswick Cossert in 31. Date filed (Month, Day, Year) Begistrar's Signature State JAN 0 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. tate of Maryland / Department of Health and Mental Hygiene Certificate of Death 2011-43378 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Daniel Ray Berry 2011 December 2:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery General Hospital Montgomery 01nev 9. Birthplace (State or Foreign Country) Corpus 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 566-90-6124 Director 1 🗓 M 2 □ F 58 Oct. 3, 1953 Christie, TX Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Director notified 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number ms 23a or must be r ō 10f. Zip Code 10g. Citizen of What Country? Funeral 802 Silver Spring Avenue 20910 United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, "natural", or iten edical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Caucasian 3 Widowed 4 X Divorced Completed other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Building Electrician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of မ 127 is marker er traumatic Raymond Earl Berry Metta Grace Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1405 Teal Lane, Frederick, Maryland 21703 Kimberly Peterson, daughter If item 2 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 0 Department Important: Il any injury or once, Brentwood, Maryland Ft. Lincoln Crematory | 1/03/2012 4 ☐ Donation 5 ☐ Other (Specify) M01102 ature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Kawe 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced Acquired Immunodeficiency disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Possible Pneumonia Sequentially list conditions Examine Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-trai Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day 1 Yes 2 No ☐ Unknown þ Completed

 P^{M}

Year

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P.O. Box 68760 Records, page 2 s of or Attending Physician:

after death.

Director, After this certifications Division of Vital

To the Hospital within 24 hours a To the Funeral L Hospital

Be ဂ္

Certificate:

Medical

Baltimore, Maryland 21215-0036

Part II. Other significant conditions of	contributing to death but not resulting in the	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown	
			24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼ No 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Death (Check	only one)
examiner? 1 Yes 2 X No	Hospital: 1 X Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing Ho	me 5 Residence 6 Other (Specify)
27. Manner of Death 1 🛣 Natural 5 🗆 Pending 2 🔲 Accident Investigatio	28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	1 28e Place of Injuny - At home form e	treet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
One Cartifies 1 X Cartificing Phys	niniam. To the heat of my knowledge, death	a consumed at the time data and place as	ad due to the equac(a) and manner as stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NO. D60999

Aruna Paspula, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18404 Oxfordshire Terrace, Olney, Maryland 20832

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar WFND#19bperFH, 1/6/12; BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 2:30 ANNA MARIE December 2011 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery General Hospital 01ney Montgomery 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days 1 🗆 M 2 🛣 Hours Min. Feb. 15, 1929 301-24-8723 82 **Director** Ohio Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is mandred other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Brookeville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19317 Richwood Court 20833 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No Specify: Completed 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Markovich Anna Krulick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Bosco/Son 3803 Street, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) Jan. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 21. Signature of uneral Servi Francis J. Collins Funeral Home Inc. school L 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final ₽nysician/ disease or condition Medical resulting in death) Examiner BIVENTRICULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events HYPERTENSION burial-trans resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ō in the past 12 months? Year Day Pregnant at time of death signed by the ar Yes 2 No 1 ☐ Yes ∠ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC ATRIAL FIBRILIATION 1 Yes 2 No 3 Probably 4 Unknown page 2 should ONSIET DIABLETER MELLITUS 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 1 Natural (Month, Dav. Year) 5 Pending 2 Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

20

29b. Signature and title of certifier

Wayn THEIRSON, mm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLARKSHUET

5540 TEN OAKS RD

28,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of Ma	aryland			ent of Hea ate of Dea		ivientai Hy					
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	Physicia Medic		Rona1d	Berger							Month 12	29	Year 201	1 6:40 P ^M		
b.,	Examir		4a. Facility Name (it	f not institution, give :	street and number)			4b. Ci	ty, Town, or Lo	cation of Deat	h	4c. County of Death				
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Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other			neral Service License		1000		22. Name	and Address o	f Facility D	anzansk	y–Go	ldberg			
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	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this. Upompleted filled in by the funeral dir	Medical	29a. Certifier 1 (Check 2 only one) 3	Certifying Physi Medical Examin Certifying Nurse	cian: To the best of er. On the basis of expressioner: To the	xami nation	and/or inve	estigation, i	n my opinion, d	death occurred	at the time, date	and place	, and due to the c	ause(s) and manner stated.		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year 0,30AM ewis Kord 01 Medical 4a. Facility Name (if not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death **Examiner** 1a/bo rear If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗷 M 2 🗆 F Months Days Hours Min (Month, Day, Director Mari land Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No D TON 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ★ Yes 2 → No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mariatone. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Store lerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Bordley lames 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniels leanore - Aunt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Md. Veterans 12-29-2011 Hurlock, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility, Bennie Smith Funeral Home 446 Dover Street, Eastan, MA Signatur _____neral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myo cardial interction Physician/ disease or condition resulting in death) minutes Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year page 2 should be detached g 🔲 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Monthly 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has performed Yes 2 2 No 1 Yes funeral director, Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 **N**o Other: 1 🗌 Yes ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? within 24 hours after oeaus.

To the Funeral Director: After and the funeral by t Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number Usekin address of person who completed cause of death (Item 23a) (Type, Print) Edoton 2 Martin MSchur gistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 2011 Banks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne urch Ucen If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Age (In vrs. last birthday) Funeral 09 - 2 Pay, 19 19 1 🗆 M 2 🕱 F 219-07-2056 Maryland 92 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Md. Talbot Oxford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Stewart Ave. 21654 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) home Elementary/Seconday (0-12) College (1-4 or 5+) Someone else's Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Brooks Lillie Banks Perry Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alicia Dodd/Grand daughter 132 Agnes St., Church Hill, Md. 21623 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State John Wesley Cem. 1 K Burial 2 Cremation 3 Removal from State 01-07-12 Oxford, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home uneral Service Licensee Signature 855 High St., Chestertown, Md. 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AORTIC VAINE SCUNTE STINULI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Completed

Ph_{sician}/

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

쭚			<u> </u>		
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year
E.	Part II. Other significant conditions co	entributing to death but not resulting in the underl	ying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
d by	COLONNIA V	TEN DILKAIN		1 ☐ Yes	2 No 3 Probably 4 Unknown
ete					l an in a man
횯	/	,		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Completed				performed	
Be	25. Was case referred to cal examiner?		26. Place of Death (Check	only one)	-
2	1 🗆 Yes 2 🗖 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Ho	me 5 Residence	6 Other (Specify) Grandaught
Certificate:	27. Mann of Death 1 Natural 5 Pending 2 Accident Investigation		28c. Injury at work?	28d. Describe how in	
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Medical	(Check 2 Medical Examir	ician: To the best of my knowledge, death occur ner: On the basis of examination and/or investigation e Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at	the time, date and pla	ace, and due to the cause(s) and manner stated.
	29b. Signature and title of sertifier)////	29c, License number	29d. l	Date signed (Month, Day, Year)

503 Cynwood Drive Suite Z Easton Mis 21601

-udwia 31. Date filed (Month, Day,

JAN 04 2012

who completed cause of death (Item 23a) (Ribe, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per FH G926 4/03/2012 Jh State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Ervan Annette Brown $10:55a^{M}$ 2011 Λ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pineview Nursing Home Prince Clinton Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 1 🗆 M 2 🗶 F 231-96-7325 75 Director Yrs. /10/1936 WashingtonDC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Prince Georges Clinton 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8209 Sonar Rd. 20735 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: black If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Childcare Provider 12 Childcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Thomas Brier Edna Mae Price Thomas Ervan Brier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Dabney-Day 8209 Sonar Rd., Clinton, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Riverdale Park 1/10/12 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, Md. Universal Mortuary Signature of Funeral Service Licenses 22. Name and Address of Facility Ru 411 Kennedy St NW Washington, 20011 23a. Part 1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between n et and Death Immediate Cause (Final Knsive Cordinassular disease Physician/ disease or condition resulting in death) Medical Due (or as a consequence of): months Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events g physician and as the burial-transit ears Exam that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pt for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 Tes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificants and the Funeral Directors. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Vcertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Year)

Box 68760

P.0.

Records,

Division of Vital

incurentene Clinton, mar

30, Name and address of person who completed cause of death (Item 29a) (Type, Print)

	For State	Oldio.	-		artment of I tificate of I		arra re			201	1 1.2201	
	Registrar 1. Decedent's Name (First, Middle)	e, Last)			imodio or .			2. Date of De		4 U 	3. Time of Death	
ian/ lical	CLARA ELIZABETI	I BROWN						Month 12/	27/20	11 Year	5:00p ^M	
iner	4a. Facility Name (if not institution		mber)		4b. City, Town, o		of Death			ounty of Dea		
-	13131 Wonderlar 5. Social Security Number	nd Way 16. Sex	7. Age (In yrs.	last hirthday)	Germant If Under 1 Year		24 Hrs	8. Date of Bir		tgomei	rthplace (State or Foreign	
il r	220-40-4265	1 ☐ M 2 🛣 F	76	Yrs.	Months Days	Hours	Min.	Month, D. 3/9/3		MI	ountry)	
٦.	Usual Residence of Decedent 10a, State 10b. County		100 0	ty, Town or Lo	nation						10d. Inside City Limits	
To Be Completed by Funeral Director					Cation						1 🖾 Yes 2 🗆 No	
Į.	MD Montgo	mery	DICK	erson	10f. Zip Code	_			10g. Citize	n of What C	ountry?	
Funeral	21000 Big Woods	s Road			20842				U.S.	A.		
Ξ	11. Marital Status	Armed F		S. 13. V	Was Decedent of F f Yes, specify Cub	lispanic Origan, Mexicar	gin? (Spe ı, Puerto	cify Yes or No- Rican, etc.)	14	. Race - Am Black, Whi	erican Indian, ite. etc.	
d by	1 ☐ Never Married 2 ☐ Ma 3 🎦 Widowed 4 ☐ Divorce				I ☐ Yes 2 🛣 No	Specify:			Sp		lack	
Completed	15. Decede	ent's Education		16a. Deced	lent's Usual Occup	oation			16b Kind		Industry ry County	
a mo	(Specify only high Elementary/Seconday (0-12)	est grade completed College (1-4 or 5+)	life. Di	kind of work done O NOT use retired,)	t of worki	ng	1	tgame: vernm	_	
Be C	10th 17. Father's Name (First, Middle,	/ act)		Billin	<u>q Servic</u>	T	oula hi	- (Eirot AA' 1-1'				
To B	Warren Foremar	•				l		e (First, Middle, e Jacks		riame)		
	19a. Informant's Name/Relations				ng Address (Street	and Numbe	er or Rura	l Route Numbe	er, City or To			
	Hattie Williams	s/sister		9 Ch	estnut S	treet	, Ga	ithersk	ourg,	MD 208	377 	
	20a. Method of Disposition 1 A Burial 2 Cremation	3 Removal from			sition (Name of natory or other pla	ce)		Date	l	•	or Town, State	
	4 Donation 5 Other (* **	Eli	_	urch Cem	- 400		/2012			le, MD	
	21. Signature of Funeral Service	_	1576	- 1	Name and Address 46 N. Wa		DII	owaen F	unera ckvi l	l Home	e 5 20850	
Г	23a. Part 1. Enter the disease, o	r complications that	caused the dea							10, 11	Approximate	
	shock, or heart failure. List Immediate Cause (Final disease or condition	A DAMES A CONTRACTOR		1	aalomoa	4					Interval Between Onset and Death 7 months	
	disease or condition resulting in death) Any otrophic lateral sclerosis 7 months Due to (or as a consequence of):											
er	Sequentially list conditions, b. Due to (or as a consequence of):											
Examiner	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury)											
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dica	d											
Physician/Medical	IF FEMALE:	220 If you ou	itcome of pregn	anov.							1	
cian	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live		al death 3	Ectopic pregnan Other (specify)	су			23	d. Date of d Month	elivery Day Year	
hysi	1 ☐ Yes 2 🔀 No g ☐ Unknown	g 🗆 Unk										
	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	inderlying cause g	iven in Part	l.				to the cause of death?	
ted	Hypertension							1 🗆			Probably 4 🗆 Unknown	
Completed by								24a. Was			utopsy findings available completion of cause of	
	25. Was case referred to medical	1			00. 5	N	N- (Ol)	1 🗆 Yes	2 No		es 2 No	
To Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	BR/Outpatier	Oth	lace of Dea			dence 6X	daugi	nter's cifyresidence	
	27. Manner of Death 1 ☐ Natural 5 ☐ Pendi	28a. Date		28b. Time of injury		ry at		28d. Describe			ony = objective	
Certificate:		igation			M 1 🗆	Yes 2	No					
Cert	4 Homicide determ	ningd 28e. Plac	e of Injury - At h ling, etc. <i>(Specit</i>		eet, factory, office			28f. Location (City or To		lumber or R	ural Route Number,	
ical	29a. Certifier 1 Certifying	g Physician: To the	best of my know	/ledge, death o	occured at the time	e, date and	place, an	d due to the ca	ause(s) and i	manner as s	tated.	
Medical	(Check 2 Medical only one) 3 Certifying	Examiner: On the bag g Nurse Practioner	sis of examination	on and/or invest	tigation, in my opini	ion, death o	ccurred at	the time, date	and place, ai	nd due to the	e cause(s) and manner stated	
	29b. Signature and title of certifie	X			29c. Licens				29d. Date :	signed (Mon	th, Day, Year)	
1		100	- ms		Doct	7305	5		12/2	-8/11		
	30. Name and address of person		,			ho===?-		MT 201	70			
ate	Jeremy J. Janss 31. Date filed (Month, Day, Year)	sen, 7 Gra	anite P	lace. #	14. Gait	hersb	urg,	MD 208	378			
ate trar	Jeremy J. Janss	sen, 7 Gra	,	lace. #	14. Gait	hersb	urg,	MD 208	378			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 4:00 AM December John Rogerson Beaton Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Regional George Prince Hospita aurel Laure If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Min 1 🛣 M 2 🗆 F Yrs. Director 86 Canada 575-60-3303 Usual Residence of Deceden 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Funeral Director Maryland 1 4 1 Prince Georges Laurel 1 ¥ Yes 2 □ No 10f. Zip Code 20708 10e. Street and Numbe 10g. Citizen of What Country? ns 23a c cmust b 9211 Montpelier USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. White þ 1 Never Married 2 X Married 1 ☐ Yes 2 😿 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) University of Maryland Elementary/Seconday (0-12) College (1-4 or 5+) Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည John Hector Beaton Ida Madeline Rogerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9211 Montpelier Dr. Laurel, Md. Helen Beaton 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State At lantic Crematory or other place) 12-24-2011 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home Rd. Laurel, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not en Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ etastatic Medical resulting in death) Due to (or as a consequence of): Examiner neumonid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-transit and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be der Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No 2 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **X**No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 2011 eu

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DHMH 17 Rev 7/2009

Registrar

Name and add

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Hospita

ress of person who completed cause of death (Item 23a) (Type, Print)

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Van Dusen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . Day 22 Physician/ Month Gwendolyn A. Blunt 2011 11:18A M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1242 Painted Fern Rd. Caroline Denton 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212-60-1666 Director 1 □ M 2**X** F 15 1951 60 Oct D.C. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Maryland Caroline Denton 1 ☐ Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 1242 Painted Fern Rd. 21629 USA ral", or items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural" Completed 3 Widowed 4 X Divorced Specify: Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Md. Environmental Hygiene. Elementary/Secondary (0-12) 12th College (1-4 or 5+) traumatic event, the Payroll Clerk Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Calvin Matthews Geraldine Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Rondell Thompson(Son) 1251 Scott Town Rd. Shady Side, Md. 20764 20a. Method of Disposition 20b. Blacko Dinconich (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 Department of Important; If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens : 12-29-11 Davidsonville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Miniame Reeseof RecilitSons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Breat LANCE Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and a for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year detached the 9 Unknown · by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed d be def 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy , page performed certificate Yes 2 N funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending work death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29d. Date signed (Month, Day, Year) 065271 12/23/11 who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 8 2011

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Suite

DK VW

Dan. 6:17 WO 21411

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30.per DVR, 9923 1-20-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
 BARBARA 2. Date of Death BELFORD Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Allegany** Western Maryland Regional Med. Ctr. Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 215-26-1656 Hours Director 80 Yrs 1 M 2 X F June 14,1931 Maryland Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Westernport 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25701 Shady Lane SW 21562 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces Black, White, etc by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 nan "natural", Medical Exar 1 Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry if. Page 1 and 2 should be liteu artment of Health and Mental Hygiene. if item 27 is marked other than "in (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elwood Wilson Crum Evelyn Irene Null 19a. Informant's Name/Relationship (Type, Print) 21562 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon E. Belford - husband 25701 Shady Lane SW Room 201 Westernport, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Ginevan Cemetery 12-24-2011 Paw Paw, West Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kimble Funeral Home 188 Mosser Avenue Paw Paw, West Virginia Enter the disease, or co 2 Part 1. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical that the death certificate be as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Regulant at time of death 5 Other (specify) asn 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy perform death? Yes 2 No 1 Yes 2XNo Physician: filled in by the funeral director, Be Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1/Natural or Attending injury 5 Pending Division 1 Yes 2 No 24 hours after death Funeral Director: A Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) #662 12,21,11 30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print)

Registrar

State

<u>Ardalan Enkeshafi</u>

68760

Box

P.O.

of Vital

32. Registrar Signature

12501 Willow Brook Rd. Cumberland, MD., 21502

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Amand	led ite		For State	23a nart	line c,	•					-	_		WCHD
Allend			1. Decedent's Name			per	pilyes			7	2. Date of De	eath	201	3. Tirrle of Death 8
	Physicia Medic	al			Czapiews	ski					Month 12	31		11:47A M
	Examin	er			ve street and number) eral Hospi	ital		4b. City, Town, Berl		Location of Death			c. County of Dea Jorcest	
	Funeral		5. Social Security N	umber 6.	Sex 7. Ag	e (In yrs. I	ast birthday)		ar		8. Date of Bi	rth	0.00	rthplana (Ctata ar Faraign
	Director		219-16-4 Usual Residence of		1 🔀 M 2 🗆 F	88	Yrs.	Wiontins	,3	TIOUIS WIII.	14721	719	23	Poland
0	show dat	tor	10a. State	10b. County	_	10c. Cit	y, Town or L	ocation						10d. Inside City Limits
No.	28a-f	Director	MD 10e. Street and Nur	Worces	ter	0с	ean I							1 ☐ Yes 2 🔀 No
÷ +	23a o		15 Moby		Dr			10f. Zip Code 218		1		10g. C	Oitizen of What C	ountry?
tra	items er mu	Funeral	11. Marital Status	DICK	12. Was Decedent E Armed Forces?	Ever in U.S	S. 13.	Was Decedent of	f His	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No		14, Race - Am	
36	alle, or xamin	d by	1 Never Marr	ied 2 🔀 Married	1 X Yes 2 ☐ If Yes, Give	No		1 Yes 2 Xt			nican, etc.,		Black, Whi	
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7/47 21215-0036	than "i e Med	Completed	(Spe		grade completed) College (1-4 or 5	5+)	life. I	OO NOT use retire	ed)	uring most of worki	ng	Ì		
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Maryland	anc N is n a		19a. Informant's Na							nd Number or Rura				, ,
∠ d e, Mar	Health em 27 ther tr		Helen V		iewski /	_	_	Moby Dosition (Name of	i	r			nes, M	D 21811
Baltimore,	perim. Tage I and 2 stood, embowing in the waryland popular trage I and 2 stood, and plant popular the propagation of the part and which Hygiene. Important: If item 27 is nierked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2		Removal from State	0	emetery, cre	matory or other p	olace Y E	em. 1/2/	Date / 2012		.11sbor	
altir	portar portar y injur		21. Signature of For			.1.7.7				s of Facility Bu		I		
O B 8	88 58		M	4/10 F	Jula .					Liam St.			, MD 2	1811
0			23a. Part 1. Enter shock, or hea Immediate Cause (rt ailure. List only	mplications that coused one cause or all line	the deat	h. Do not en	ter the mode of di	,		or respiratory a	rrest,		Approximate Interval Between Onset and Death
	nysician/ Medical		disease or condition resulting in death)		a. Due to (or as	a consequ	uence of):	1-111		, ,				
	xaminer	L	Sequentially list co	nditions.	b. 50	ope		Shall						
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executed	in and		that initiated events resulting in death) I	S	c. Due to (or as	ersis a consequ							-	
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Box 68760	ding p se as t		IF FEMALE: 23b. Was decedent	prognant	23c. If yes, outcome	of pregna	incy						23d. Date of de	olivan.
Box death o	e atten d for u	iciar	in the past 12 in The Past 12 in The	months?	4 🔲 Pregnant a			☐ Ectopic pregna☐ Other (specify)		/			Month	Day Year
P.O. Box	by the	Phys	9 Unknown		9 ☐ Unknown contributing to death b	ut not roc	ulting in the	underlying source	aive	an in Port I	00 814			o the cause of death?
Eugene G C 200 160 Sion of Vital Records, P.O. Attending Physician: The law requires that the	signed d be de	d by	rartii. Other sigilii	icant conditions	contributing to death b	dt not les	diting in the	underlying cause	give	en in regict.				Probably 4 Unknown
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of Vi	r this ceral dir	6	1 ☐ Yes 2 ☐ 27. Manner of Death	1 100	1 Umpation 28a. Date of inju	ry	ER/Outpation 28b. Time of	int 3 🗆 DOA	other	4 L Nursing Ho	me 5 Resi			cify)
F LOS	ath. r: Afte ne fune	Certificate:	1 Natural 2 Accident	5 Pending Investigati		v, Year)	injury	W	ork?	Yes 2 No	2001.00		, occanica	
Division	fter de lirecto n by th	ertii	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine		iry - At ho c. (Specify	me, farm, st	reet, factory, offic	e		28f. Location (City or To			ural Route Number,
D	ours a		29a. Certifier 1	Certifying B	ysician: To the best of	my knowl	ledge death	occured at the tir	me.	date and place, an	d due to the ca	ause(s) a	and manner as si	tated.
ne Hos	within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2	☐ Medical Exa		xamination	and/or inve	stigation, in my opi	inior	n, death occurred at	the time, date	and plac	e, and due to the	cause(s) and manner stated.
70 th	vith To ti	_	29b. Signature and	title of certifier	$M \cap M$			29c. Liçer	nse	number C	-	29d. D	ate signed/(Mon:	th, Day, Year)
			30. Nafile and addre	ass of parson with	o coffipleted cause of d	eath (Item	26a) (Time	Print)	7	7 0 3	7 ,	14	21/11	
_			Antho	1 Ver	ul 473	3/-	ENM	in /	1	har 15	Evlu	n	W) Co	1811
	Stat	e	31. Date filed (Mont	JAN U 5	2012 32. Registra	ar's Signat	ture	varke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12 28^{ay} 2011 Adele Clompus 6:52 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home Of Greater Washington Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 - F Months Days Hours 4-2-1928 148-22-5615 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1x Yes 2 □ No Montgomery Rockville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 125 Talbott Street 20852 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify: White Specify 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Sauber Rose Rovner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Clompus - Son 3301 Sir Thomas Dr., #23, Silver Spring MD, 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Garden Of Remembrance 1-1-2012 Clarksburg, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Lies Edward Sagel Funeral Direction Rockville Pike, Rockville, Maryland 20852 ateixine disease; or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1, Enterth Immediate Cause (Final Onset and Death 2 months Congestive Heart Failure disease or condition resulting in death) Due to (or as a consequence of Aortic Stenosis months Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)

Physician/ Medical Examiner

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

or 28a-f show notified at

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mit. Page 1 and 2 should be filed within 72 hours after death with the satment of Health and Mertal Hygiene. ovicatrist if item 27 is marked other than "natural", or items 23a or ovicatrist if item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be a injury or other traumatic event, the Medical Examiner must be a

permit. Page 1 a
Department of H
Important: If ite
any injury or ott

2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

2

Examine and transfer physician the burial Physician/Medical

þ Completed Be ္ဝ Certificate:

page 2 certificate

this funeral

within 24 hours after death To the Funeral Director: / completed filled in by the i

within 2 To the F

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Cause (Disease or iinjury	C		
resulting in death) Last	Due to (or as a consequence of):		
	d		
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions Deep vein throm	contributing to death but not resulting in the underlying cause given in		o use contribute to the cause of death? 2X\int No 3 \sum Probably 4 \sum Unknown
Pulmonary Embol Gastric Lymphom		24a. Was an autopsy performed?	
Was case referred to medical examiner?		Death (Check only one)	
1 ☐ Yes 2 🕱 No	Hospital: 1 Inpatient 2X ER/Outpatient 3 DOA Other: 4 [☐ Nursing Home 5 ☐ Residence	6 ☐ Other (Specify)
7. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury work? 1 □ Yes	28d. Describe how inj	jury occurred

🔭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D35168

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

12-28-2011

State Registrar 31. Date filed (Month, Day, Year, JAN 03

Linda Benson MD.

6 Could not be

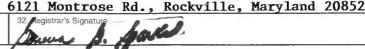
determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Suicide
4 Homicide

29b. Signature and title of certifier

29a. Certifier



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State	State of Maryl	and / Dep		lealth and I	Mental Hyg	jiene		43390
	_		Registrar 1. Decedent's Name (First, Middle, Last))	Cei	lineale of D	eatri	2. Date of Dea	Reg. No. 2	111	3. Time of Death
п	Physicia		Kuong Nam Chung					Month Decembe			12:03 a ^M
1	Medic Examin		4a. Facility Name (if not institution, give s			4b. City, Town, or	Location of Death			y of Death	12103 4
	LAGITIII	CI	Montgomery Hospic	e-Casey Hous	se	Rockvil				tgomery	v
	Funeral	5	Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1		ce (State or Foreign
>	Director			M 2 □ F 82	Yrs.	WORKIS Days	TIOUIS IVIIII.	Oct. 14			ina
	nd now	J.	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation		0001 11	, 1,2,		I. Inside City Limits
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	or 28	Dir	MD Montgot	mery	Rockv	111e 10f. Zip Code			10g. Citizen of	What Country	?
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-		ce - American	
98	fter d ", or i amin	by	1 Never Married 2 X Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 Tes, specify Cubar 1 ☐ Yes 2 ☐ No		Mican, etc.)	Specify	ick, White, etc Asia i	
21215-0036	tural'	Completed by	3 Widowed 4 Divorced	Year or Dates.						у.	
15-	72 ho n "na ledic	nple	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa kind of work done do O NOT use retired)	ation uring most of worl	king	16b. Kind of E	Business/Indus	stry
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/lar	d be f Aenta Irked Itic e	၀	Unknown	Chung			Unkno	wn			
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Typ			ng Address (Street a					de)
	nd 2 sealth m 27		Peter L. Chung/Son	n	13213	Ardennes	Avenue,	Rockvil	1e, MD	20851	
ore	le 1 al t of H If itel or oth		20a. Method of Disposition 1		 b. Place of Dispo cemetery, crer 	sition (Name of natory or other place	Jan	Date 6	20c. Location	- City or Town	n, State
ţ	t. Pag tmen tant: tjury		4 Donation 5 Other (Specify)	Ga		aven Ceme			Silver		, MD
Baltimore,	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service License	e	s Collins	Funeral	Home 1	Inc.			
			23a. Part 1, Enter the disease, or compli	ications that caused the d							MD 20901
			shock, or heart failure. List only one		icatii. Do not cht	sr the made of dying	, saon as cardiae	or respiratory arre	,,,	In	nterval Between
and it	Physician/ Medical		disease or condition resulting in death)	Lung Cance Due to (or as a cons							
The same	Examiner			Due to (or as a cons	equence on.						
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of	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year	28b. Time of injury	28c. Injury work?	at ?	28d. Describe ho	ow injury occur	red	
ion	Attending P death. ctor: After t	ifica	2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆 `	Yes 2 No		-		<u>.</u>
Division of Vital	I or Attenct after death Director: of in by the	Certificate:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location (Sa City or Town		ber or Rural Ro	oute Number,
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death a state death to the Funeral Director. After this certificate has been signed by the Confidency filled in by the funeral director, page 2 should be detach		29a. Certifier 1 Certifying Physic	cian: To the best of my kr	rouledge deeth	nourred at the time	data and place	and due to the sai	uno(a) and mar	nor ac ctated	
	24 hos Fun	Medical	(Check 2 Medical Examin	er: On the basis of examinate Practitioner: To the best	ation and/or inves	tigation, in my opinior	n, death occurred a	it the time, date ar	nd place, and di	ue to the cause	e(s) and manner stated
	o within the	2	29b. Signafure and line of certifier	Traditioner: To the best	or my knowledge	29c. License			29d. Date signe		
			XISTAH 1	Meles,	CRNP	R14320	11		12/3	31/11	
			30. Name and address of person who co	empleted cause of death (I	tem 23a) (Type, F	Print) #100			- / -	/	
			Debrah Miller, CR			rive, Roc	kville,	MD 20850)		
	Stat		31. Date filed (Month, Day, Year)	37. Registrar's Sig	gnature-	N.J.					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43391 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ David Cordell Cich 4:50 P M December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bowie Health Center Bowie Prince George's Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Months Min. (Month, Day, Year) Hours Director 295-36-9834 1 ▼ M 2 □ F 71 19, Ohio show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 ☐ Yes 2x No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>13505 Steeplechase Drive</u> 20715 U.S.A. iral", or items. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examination þ 1 Never Married 2 XMarried 1 Yes 2 No Maryland 21215-0036 Army 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Marketing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stanley Cich Josephine Romev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Judith J. Cich - Wife</u> 13505 Steeplechase Dr., Bowie, MD 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cometery, crematory or other place) Metro Crematory 12-29-2011 Baltimore, Maryland of Fur eral Service Licensi 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death .Ph₁sician/ Acute Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Asystole Sequentially list conditions ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten e detached for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dyslipidemia To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: autopsy 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 X No မ 1 🗌 Yes 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 🕅 Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the P 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe December 27, 2011

10 4

Dr. Kaveh Sadeghi, 31. Date filed (Month. State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12150 Annapolis Rd, Suite 308, Glenn Dale, MD

DEC 2 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death plickas Physician/ Beatrice December 2011 2:40 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Annapolitan Assisted Living Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 X F Days Min. New York **Director** 91 <u>069-16-2983</u> 1920 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Anne Arundel <u>Glen Burnie</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 8215 Anglers Edge Court 21060 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ϊ No Specify: "natural", Completed 3 X Widowed 4 □ Divorced White Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator Ma Bell 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nils Stenholm Bridget Leddy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8215 Anglers Edge Court Glen Burnie, MD 21060 Jacqueline Holmgren/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Meadowridge 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Donation 5 Other (Specify) 12/29/2011 | Elkridge, MD Memorial Park

1.22. Name and Address of Facility Robert E. Evans Funeral Home . Signature of Funeral Service Licensee Kuis 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to himself cause. Enter Underlying Due to (or as a consequence or) that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSISTEC Other: 1 ☐ Yes 2 🔀 No မှ 4 Nursing Home 5 Residence 6 (A) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 X Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Digital Dr. #G Lindbirum MD 21090 705 Jinson

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

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			State Registrar				Ce	ertificate	of D	Death			Reg. No	<u>. 20</u>		40000
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- 100	Medic Examin				Connors ive street and number)		AKA	Betty		Location of	of Death	Deceill				4:55 P M
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the the	pomers, ago, the fath and Mehral Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Nur			-		10f. Zip					_	itizen of W		-
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ir dea	or ite	by Fu	 Marital Status Never Marr 	ied 2 🗆 Married	12. Was Decedent Armed Forces?		5. 13					cify Yes or No- Rican, etc.)	-	14. Race Black	- Americ , White,	
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Baltimore,	or of			Cremation 3	☐ Removal from State	. C	emetery, cr	oosition (Name ematory or oti	her place			ate unk	1	ocation - 0	•	
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of Vital Records, P.O. Box 68760 Physician: The law requires that the death certificate be	igned by the a be detached t	by P			contributing to death to	out not res	ulting in the	underlying ca	ause give	en in Part I	l.	23e. Did t	tobacco (use contrib	ute to th	e cause of death?
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of Vital 19 Physician:	certificate ha lirector, page 2	m,	25. Was case referre examiner? 1 ☐ Yes 2 ☐	ed to medical	Hospital:				Other	ce of Deat	-			37		Doughton
of V	er this	e: 10	27. Manner of Death	Λ	28a. Date of inju	iry	28b. Time	of 28	c. Injury	4 L Nu		ne 5 Resi				Daughters Residence
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death December 29 2011 Physician/ 7:07 Russell C. Collins Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Berling Nursing & Rehab Center Berlin Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
MD 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 12-25-1923 Days Director 222-18-9040 88 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Worcester Whalevville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11834 Steammill Hill Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2X No 1 ☐ Yes 2 ☐ No Specify: Specify Black 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ed other than "event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed Landscaper Be Collins, Russel Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George W. Collins Ethel McGreger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>James R. Leonard/Stepson</u> Penn Street, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) UM Cem 1-6-2012 Bishopville, MD 22. Name and Address of Facility 917 W. Signature of Funeral Service Licensee Isabella St. Bennie Smith Funeral Home rusc Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year 4 ☐ Pregnant at time of death g ☐ Unknown Yes 2 No tor: After this certificate has been signed by the the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 😾 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐XNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Hospital or Attending P 124 hours after death.
 Funeral Director: After t 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Tyes 2 🗌 No М Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature ar title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R 135131 December 29, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Savage, Pennie CRNP 9715 Healthway Dr, Berlin, 21811 31. Date filed (Month,

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar	State of N		d / Depa	artme		lealth a		lental Hy		20		43395	
Physicia		Decedent's Name (First, Middle, I Teresa					2				2. Date of Death Month Pay Year Year			3. Time of Death	
Medic Examine		4a. Facility Name (if not institution, g	acility Name (if not institution, give street and number) stern MD Regional Medical Center				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la 218–60–2026 1 □ M 2 💢 F 50				birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.				8. Date of Birth (Month, Day, Year) 08/31/1961			9. Birthplace (State or Foreign Country) Maryland		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ector	Usual Residence of Decedent 10a. State 10b. County MD Alle	, Town or Loc	or Location aberland						od. Inside City Limits					
	Funeral Director	10e. Street and Number 1109½ Frederick Street				10f. Zip Code 21502					10g. Citizen of What Country? USA				
	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 Y No			13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ▼ No Specify:					14. Race - American Indian, Black, White, etc. Specify: White				
	Completed		(Specify only highest grade completed) [Rementary/Secondary (0-12) College (1-4 or 5+)				Decedent's Usual Occupation Give kind of work done during most of working fe. DO NOT use retired) Laborer					16b. Kind of Business/Industry Private Sector			
	To Be	17. Father's Name (First, Middle, Las Leon	Dill	.llman 18. Mother's Name Emma				(First, Middle, Maiden Surname) Jane Rang							
		19a. Informant's Name/Relationship (Type, Print) Leon G. Dillman / Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12816 Ioka Drive, NE, Cumberland, MD 21502													
Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory 12/21/2011 Cumber													
permit. Departi Import any inj		21. Signature of Funeral Service Ho	ensee 20075							ms Fam: , Cumbe	_			lome, P.A. 21502	
Physician/		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Congestive heart failure													
Medical Examiner	Ļ	resulting in death) Sequentially list conditions,	Due to (or a	salconsequ de(- 1	villie		lrome								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													
		Toodiang in doday East	d												
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1									23d. Date of delivery Month Day Year			
	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
	Completed									24a. Was autor perfo	psy ormed?	p		sy findings available inpletion of cause of	
ysician: is certifica director,	Be (25. Was case referred to medical examiner?		26. Place of Death (Check											
To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this or completely filled in by the funeral dire	욘	1 ☐ Yes 2 ☑ No	Hospital: 1 In Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)												
	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could no	tion (Month, D												
oital or At urs after o rral Direct		4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)				
the Hosphin 24 hc	Medical													se(s) and manner stated. tated.	
S with		29b. Signature and title of certifier		29c. License number					29d. Date signed (Month, Day, Year)						
MAS		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelly Liu . 12500 Willowbrook Rd, Cumberland, MD. 21502												502	
State Registra		31. Date filed (Month, Day, Year) DEC 20 2011	32. Regis	trar's Signat	wre	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D#20th31 2011 4:30 AM M Daniel Patrick Davis Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Calvert 1861 Old Field Drive Huntingtown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 0770671954 215-58-8252 57 Director Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Calvert Unitngtown 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20639 23a Funeral 1861 Old Field Drive United States items Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian. Armed Forces? Black, White, etc. white þ ō 1 Never Married 2 Married hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) construction steamfitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew Davis Mary Baldwin permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1861 Old Field Drive Huntingtown Maryland 20639 Donna L. Davis- spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 01/03/2012 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State Metropolitan Funeral Service Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULLHONARY YEARS Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Ď Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 N 2 No ours after death.

eral Director: After this certific filled in by the funeral director, Hospital or Attending Physician; To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ILL ge and address of person who completed cause of death (Item 23a) (Type, Print)

10

Box 68760

P.O.

Records,

of Vital

Division

Registrar

-WSTI 32. Registra s Signature

Hospilal Rd Princes Frederick, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43397 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ NZIVBAN Month 2 ELINOR 07/5 M Medical 2011 **Examiner** 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Country) 199-16-9177 **Director** 87 1 🗆 M 2 📝 F 04/20/1924 PA Usual Residence of Deceden 28a-f show 10a. State 10b. County the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MDAnne Arundel Arnold 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 1485 Grandview Road 21012 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ Xo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XXo Specify. 3 ₩ Widowed 4 □ Divorced Completed Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Home maker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jesse Williams Catherine Doyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Kathleen Scott (daughter) 1485 Grandview Road Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State Seven Dolors Cem. 12/29/2011 S. Huntingdon Twp. PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Servi 22. Name and Address of Facility Hardesty Funeral Home P.A. 17/ 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner EARS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and or use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day 1 Yes 2 Pregnant at time of death Year been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy within 24 hours after death.

To the Funeral Director. After this certificate to completely filled in by the funeral director, page performed death? Yes 2 No 1 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and title of certifie 2 20 15 Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLS 445 M D21401 GLENTA Hory gistrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mai		artment of Health and N <i>tificate of Death</i>	lental Hygle Reg	201	43398
	Physicia		1. Decedent's Name (First, Middle, Last) Gisela Ecker			2. Date of Death Month	^{Day} O, 2Ŏ ^e ar1	3. Time of Death 5:43 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death	Becomper	4c. County of Deat	
-	Funeral	•		L Center (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		505-54-7610 1 □ M 2 🖾 F Usual Residence of Decedent	75 Yrs.	Months Days Hours Min.	Sept. I,	1936 G	ermany
	ryland -f shov ied at	ctor		10c. City, Town or Loc				10d. Inside City Limits
	the Ma or 28a e notifi	Director	Maryland Frederick 10e. Street and Number	Frede	10f. Zip Code	10g	. Citizen of What Co	1 ☒ Yes 2 ☐ No
	ith with ms 23a must b	Funeral	706 West Patrick Street	Lio V	21701		ited Stat	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	à	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	0	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	city Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
7	า 72 ho an "nat Medica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupation kind of work done during most of worki O NOT use retired)	ng 16	b. Kind of Business	Industry
7.17	d withir tygiene ther than nt, the	Be Co	Elementary/Seconday (0-12) College (1-4 or 5+)	Hor	memaker		Own Home	nlr \
/lanc	2 should be file th and Mental H 7 is marked of traumatic ever	10	17. Father's Name (First, Middle, Last) (unk.)		18. Mother's Name	e (First, Middle, Maid	den Surname) (u	11K.)
	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en	i	19a. Informant's Name/Relationship (Type, Print) Patricia Grossnickle / Frie		ng Address (Street and Number or Rura 9 Pleasant Walk Ro	l Route Number, Cit 1, Myersv	y or Town, State, Zi ille, MD	21773
nore	age 1 ar ent of H nt: If iter y or oth		20a. Method of Disposition 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place) Decei	nber Ib	c. Location - City or	
Baltimore,	permit. P. Departme Importan any injur.		21. Signature of Fundial South Licensee	瓷	n Crematory i 20 e\stravemsspineral : 501 Catoctin Moun	Services,	Skkot Co	dy P.A.
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2,00	ficate b g physic as the b		d	5				
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as, r.o	quires that t en signed b ould be deta	ξ	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac		the cause of death?
Records,	The law recate has be page 2 sh	Completed				24a. Was an autopsy performe 1 Yes 2	prior to death?	topsy findings available completion of cause of
N I	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient	t 2 🗆 ER/Outpatient	26. Place of Death (Check		e 6 🗆 Other (Spec	(6.)
5	ling Ph		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Y	28b. Time of	28c. Injury at work?	28d. Describe how i		11 y y
IVISION OF	or Attend after death Director: / in by the f	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (5	- At home, farm, stre Specify)	M 1 ☐ Yes 2 ☐ No let, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
ב	e Hospital	Medical	29a. Certifier 1 M Certifying Physician: To the best of my (Check 2 ☐ Medical Examiner: On the basis of examonly one) 3 ☐ Certifying Nurse Practioner: To the best of my one) 4 ☐ Certifying Nurse Practioner: To the best of my one) 5 ☐ Certifying Nurse Practioner: To the best of my one) 6 ☐ Certifying Nurse Practioner: To the best of my one) 7 ☐ Certifying Nurse Practioner: To the best of my one) 7 ☐ Certifying Nurse Practioner: To the best of my one) 7 ☐ Certifying Physician: To the best of my one) 8 ☐ Certifying Physician: To the best of my one) 8 ☐ Certifying Physician: To the best of my one) 9 ☐ Certifying Physicia	mination and/or investi	igation, in my opinion, death occurred at	the time, date and p	lace, and due to the	cause(s) and manner stated.
	To th within To th comp		20h Signature and title of certifier		20a License number	207	Date signed (Month	
			30. Name and address of person who completed cause of deat ANSAR FUAN AD (IS North Howard 27) 31. Date filed (Month, Day, Year) 32. Tegistrar's	th (Item 23a) (Type, Pr	THINDAE MD 2120)		/ /	
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	maked .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ella Florence Elliott Dec 2011 9:30 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hosehold of Angels Crofton Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 □ M 2 □ F o*1*%65%14921 Washington DC Director 579-14-1286 90 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Millersville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 407 Fawn Haven Ct. 21108 21108 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 💢 No Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Mortgage marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Richard Golden Henrietta Saul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Marnato (daughter) 407 Fawn Haven Ct. Millersville, MD 21108 item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or other 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12/28/2011 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home Annapolis Rd Gambrills, MD 21054 851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fnysician disease or condition Medical resulting in death) Examiner Sequentially list conditions if any leading to immediate Examiner Due to for as a consultuence of cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year this certificate has been signed by the rail director, page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Tes funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 10 Hospital Other: 1 Tyes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specif 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29 c. License number 29d. Date signed (Month, Day, Year) 850 e of death (Item 23a) (Type, Print) State 8

Registrar

			Please	Type or Print in						egible.	
			For	State of Maryla				Mental Hy	giene	011	1 21 00
			State Registrar		Cei	tificate of L	Death		Reg. No.	.011	43400
	Physicia Medic		1. Decedent's Name (First, Middle, Las Bernard S.	Frankl	in =	Jr		2. Date of Dea	30 Day	Year	3. Time of Death
- Bridge	Examir		4a. Facility Name (if not institution, give	street and number)	2 (-(r Location of Death	1	4c. Cou	nty of Death	
-			Hone Arad	of Medi	W COK	Annapo			Anne	e Aruno	le1
*.	Funeral		5. Social Security Number 6. Security Number 1. Sec		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	:h y, Yea <i>r</i>)	9. Birthp Count	lace (State or Foreign ry)
	Director		Usual Residence of Decedent	X M 2 □ F 64	4 Yrs.			10/09/	1947	Wash	ington, DC
	at at	ō	10a. State 10b. County	10c.	City, Town or Lo	cation					0d. Inside City Limits
	faryla 3a-f s tified	ect	MD Anne Art	ındel S	Shady Si	de					1 ☐ Yes 2 🏋 No
	or 2	اقا	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	try?
	with s 23a ust b	Funeral Director	4876 Idlewilde	Road		20764			U.5	S.A.	
	item;	Fu	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp	pecify Yes or No-		Race - America	
36	", or amin	b	1 X Never Married 2 Married	1 Yes 2 No		1 ☐ Yes 2 🗓 No		o riidan, etc.)		Black, White, e	etc.
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15-	72 ho "na" n ledic	Jple	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual Occup kind of work done o	during most of wor	king	16b. Kind o	f Business/Inc	dustry
21215-0036	ithin ene. r thar the N	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+		o NOT use retired) eacher			Prince	Georg	e's Schools
9	led w Hygi othel ent, 1	Be	17. Father's Name (First, Middle, Last)		<u> </u>	eacher	18. Mother's Nar	_			
<u>a</u>	be fi ental rked ic ev	욘	Bernard Sylveste	er Franklin			Glady			thieson	1
Maryland	nould ind M s ma umat		19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street :					
Σ	d 2 sl alth a 127 i er tra		Barry H. Cornwall	l, P.R.	4876	Idlewild	de Rd., S	Shady Sid	de, MD	20764	+
ē,	1 an of He item		20a. Method of Disposition	206	o. Place of Dispo		I I	Date		on - City or To	wn, State
E	Page nent c ant: II		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State		tan Crem	· •	/01/2012	Alexa	ndria.	VA
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signality of Funeral Service Licens	-		. Name and Addres	-	ausch F			
Ω	ea m m e		Deso/	Duban	L 8	325 Mt. H					
п			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	ofications that caused the de	eath. Do not ente	er the mode of dyin	ig, such as cardiac	or respiratory arr	rest,		Approximate Interval Between
ed. F	hysician/		Immediate Cause (Final disease or condition	Materita	4, 11	ms CE	aN(Ex	7		1	Onset and Death
أمر	Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	- ,	11 00.				
Е	LAGIIIIICI	<u>.</u>	Sequentially list conditions,	b. bith	(~	etasta.	Sil				wells
	si ti	Examiner	Sequentially list conditions, if any, reading to himmediate cause. Enter Underlying	Due to for as a sone	equalitie of;						
	ecute and I-tran	xaı	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):					-	
	be executed sician and burial-transit	ज्ञ								- 4	
68760	cate phys s the	Physician/Medic	V	d							
89	certifi nding use a	₹	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	gnancy				23d.	Date of delive	erv
Вох	eath e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 Live Birth 2 F	etal death 3 L of death 5 L	Other (specify)	cy 		4		Day Year
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P.O.	s that	by F	Part II. Other significant conditions co		resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use co	2 1	e cause of death?
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of Vital Records,	aw re as be	Completed by						24a. Was autop		b. Were autop	sy findings available inpletion of cause of
Re	The I	S						perfo	rmed?	death?	2 🗆 No
<u>a</u>	ertific ector,		25. Was case referred to medical examiner?	-1-		26. Pl	ace of Death (Chec	ck only one)		-	S 9
>	hysio this c	유	TE Yes 27 No		☐ ER/Outpatier		4 □ Nursing H	ome 5 Resid	lence 6 🗆 C	Other (Specify)	
0	After funer	ate	27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work	?	28d. Describe h	ow injury occ	urred	
Sio	death death stor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		home form str		Yes 2 □ No	ODS Leasting (C	Average and Alexander		Octoba Musebas
Division	after after Direc	Š	4 Homicide determined	building, etc. (Spec	cify)	eet, lactory, office		28f. Location (S City or Tow		mber or Hurai	Houte Number,
	spita nours neral y filled	ical	29a. Certifier 1 Certifying Phys	ician: To the best of my kno	owledge, death o	occurred at the time	e, date and place,	and due to the ca	use(s) and m	anner as state	d.
	to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical Exami	ner: On the basis of examinate Practitioner: To the best of	tion and/or invest	tigation, in my opinio	on, death occurred a	at the time, date a	nd place, and	due to the cau	se(s) and manner stated.
:	Vith To th		29b. Signature and Talle of certifier			29c. License	e number		29d. Date sig	ned (Month, E	Day, Year)
			102	MO		06	1472		15	311:	1105
JR	w		30. Name and address of person who c	1						*	
ak			31. Date filed (Month, Day, Year)	Tan, Mc		1 Medical	L Parkway	, Annapo	olis, N	MD 214	401
	Stat Registra			32. Registrir's Sig	-	backer					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6.55 PM 12724/2011 OMIE ELIZABETH FITZGERALD Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgamery Olney 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Days Hours Months Min 04/07/1973 214-86-0100 Yrs Director 38 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 XYes 2 No MD Montgamery Germantown 10e, Street and Number items 23a or ner must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 13152 Country Ridge Drive 20874 IISA filed within 72 hours after death ral Hygiene.
Ad other than "natural", or itemsevent, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Storage Facility Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or com-Clark Wayne Smith, II Mary Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Fitzgerald/husband 13152 Country Ridge Drive, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Svc | 12/31/2011 Hanover, MD Signating of Funeral Service Licensee 22. Name and Address of Facility Snow en Funeral Home, P.A. 246 N. Washington St., Rockville, MD 20850 11015 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ enticular disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** my o cardial Sequentially list conditions, it any leading to it mediate cause. Enter Underlying Dusi to for as air. Examir The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown ō Day Pregnant at time of death the 9 Unknown ρ signed I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? renal disease 24a. Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director name. Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 XNo Other: ၉ 1 Nnpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Bichhum 754996 December 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bichhuona M.Dinh 18101 Prince Phillip Drive, Olney, MD 20832 31. Date filed (Month, Day, Year) State JAN 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of N State of N Registrar	laryland / Depa <i>Cer</i>	artment of Health tificate of Death	n and Men	tal Hygier		1 43402
П	Physicia	n/	Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death
	Medic	al	Dana D. Frank 4a. Facility Name (if not institution, give street and number)		[4 6b 7		ecember		
-	Examin	er	5124 Chalk Point Road		4b. City, Town, or Location West River			4c. County of Dea Anne Ar	
	Funeral Director		<u></u>	ge (In yrs. last birthday) 79 Yrs.		er 24 Hrs. 8. D	Date of Birth Month, Day, Yea 1/18/19	g. Bi	rthplace (State or Foreign ountry) SSOURI
	nd how at	<u>_</u>	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Loc	cation				10d. Inside City Limits
	//anyla :8a-f s tified	recto	Maryland Anne Arundel		t River				1 ☐ Yes 2 🛣 No
	th the ? 3a or 2 t be no	Funeral Director	10e. Street and Number 5124 Chalk Point Rd.		10f. Zip Code 20778		10g.	Citizen of What C	ountry?
	eath wi	Fune	11. Marital Status 12. Was Decedent	Ever in U.S. 13. V	Vas Decedent of Hispanic C			14. Race - Ame	erican Indian,
9000	urs after d :ural", or i	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Ves Cive 3 ★ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes Cive Year or Dates.	No	Yes, specify Cuban, Mexic		ı, etc.)	Black, Whit	white
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 1 year	5+) (Give k	ent's Usual Occupation ind of work done during mo O NOT use retired) ibrarian	ost of working	P	Kind of Business Trince Ge Sounty	
nd	filed w tal Hyg d othe event,	o Be	17. Father's Name (First, Middle, Last)			ther's Name (Firs	t, Middle, Maide	en Surname)	
ryla	d Ment marke matic	υ	Harvey Jeul Dudding 19a. Informant's Name/Relationship (Type, Print)				h Marie		
, Ma	d 2 shc alth an 1.27 is er trau		Sharon M. Plympton/ Daughte		g Address (Street and Num 4 Chalk Point				' '
Baltimore,	ge 1 an nt of He : If iten or oth		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Removal from State		natory or other place)	Date	İ	Location - City o	
itir.	nit. Parartmer ortant injury		4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Ricenses	Kalas Cr	ematory Name and Address of Fac	1-3-201		Edgewate	
ä	Depar Impo any ir		Mult Halan		973 Solomons				
- 20	Physician/		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Immediate Cause (Final	Α.	r the mode of dying, such a			ra .	Approximate Interval Between Onset and Death
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	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	a consequence of,					
	ate be executec ohysician and the burial-transi		that initiated events C.	a consequence of):					
3760	ficate g physas the	Medical	d						
õ R	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3 _	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
% O. Y.	requires that the been signed by the should be detach	þ	Part II. Other significant conditions contributing to death t	out not resulting in the ur	nderlying cause given in Par	rt I.			o the cause of death?
Vital Records,	law requi nas been e 2 shouk	Completed				h	24a. Was an	24b. Were au	utopsy findings available
Yec Y	sician: The law is certificate has k	Com					autopsy performed? 1 Yes 2 X	? death?	completion of cause of
Ē	Physician: this certific al director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Other	eath (Check only	,		
O T <	iding Phys th. After this funeral dir	e: To	27. Manner of Death 28a. Date of inju	ient 2 ER/Outpatient ury 28b. Time of	28c. Injury at		5 X Residence Describe how in	6 Other (Specially occurred	cify)
00	r Attending er death. rector: Aft by the fun	Certificate:	1 Matural 5 Pending (Month, Da 2 Accident Investigation 3 Suicide 6 Could not be	y, Year) injury	M 1 ☐ Yes 2	□ No			
Division of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director After this certificate I completed filled in by the funeral director, page		4 Homicide determined 28e. Place of Injury building, etc.			C	City or Town, Sta	ite)	ıral Route Number,
	To the Hospital or within 24 hours aftr To the Funeral Dir completed filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e 3 Certifying Nurse Practioner: To the	my knowledge, death of examination and/or investigation and the state of my knowledge, d	ccured at the time, date and gation, in my opinion, death	d place, and due occurred at the tire	to the cause(s) me, date and pla	and manner as st ice, and due to the	ated. cause(s) and manner stated. I
	Some # This	-	29a. Certifier (Check 2 Medical Examiner: On the best of conly one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier when and address of person who completed cause of decrease of the 20 Medical Examiner: On the basis of each of the 29b. Signature and title of certifier when and address of person who completed cause of decrease of the 20 Medical Examiner: To the best of the 20 Medical Examiner: On the best of the basis of the 20 Medical Examiner: On the best of the be	w,	29c. License number	3	29d. [Date signed (Mont	h, Day, Year)
	12		30. Name and address of person who completed cause of d	leath (Item 23a) (Type, Pr	int)	1 1.10	+21.10	c M0	
	Stat	e	31. Date filed (Month, Day Year) 4 2012 32. Registra	ar's Signature	1	(4,000)	· VINE		
	Registra	-	ONIT UT LUIL SEN	un B. S	acked.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 22, 2011 Godfrey 12:41 A.M Carol Ann Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Calvert Memorial Hospital Prince Frederick Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 M 2 💢 02/08/1947 Virginia 225-70-0838 **Director** 64 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tes 2 No Calvert Huntingtown 10e. Street and Number 10g. Citizen of What Country? Funeral 255 Walton Road 20639 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. r than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 2 💢 No 1 ☐ Yes 2 🗓 No Specify: Completed 3 X Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Car1 Dempsey Hautz Maupin Marv Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Godfrev, Jr... 4148 Mt. Olney Lane, Olney, son MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Remover from State 4 ☐ Donation 5 ☐ Other (Specify) So. Memorial Gardens 12/29/2011 Dunkirk, MD ign is e of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failule. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ erebral disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Due to (or as a nsequence of Exami Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Dav Year Pregnant at time of death the g Unknown 9 Unknown been signed by 1 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has performed Yes 2 2 🗌 No I ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes ျပ 1 Inpatient 2 FR/Outpatient 3 IDOA this 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending injury Accident Investigation М 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 53298 12/22/11 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) TRU HUSP. Memorial Drew Fuller vert Hosp MD 20678

State Registrar Date filed (Month, Day, Year,

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec 20. 2011 2141 Eleanor Grav Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany 9. Birthplace (State or Foreign Country) PA 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 K Days ⁶⁴1923 **Director** Jun 18, 216-22-7312 88 Usual Residence of Decedent shov 10b. County 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 28a-f 1 XYes 2 No 10e. Street and Numbe ŏ 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 21502 USA 706 Baker Street 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ö 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 XWidowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grav's Tavern owner/operator Be any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Carol Keifer Milton Freeman Welsh permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
704 Baker Street Cumberland MD 21502 Jeanette Pastorek daughter 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20c. Location - City or Town, State Date 1 Burial 2 Termation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 12/21/20 MD Cresaptown Signature of Funeral Service 22. Name and Address of Facilities at Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner considerable list out office s if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 2 **X**No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Vas Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ္ 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oldraun Road Cumberland, MD 2150 517 ithan M.D. Nagaratham Year 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Athos Giacchetti Physician/ ^{Day} 29, 2011 7:00 p. M December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2301 Oak Drive Ijamsville Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 360-36-5846 Hours 1 XM 2 □ F 90 **Director** January 1, 1921 Italy 28a-f show 10a. State with the Maryland notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Ijamsville 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code "natural", or items 23a or edical Examiner must be 10g. Citizen of What Country? Funeral 2301 Oak Drive 21754 USA . Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
tant! If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner muny or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 21215-0036 1 ☐ Yes 2 X No Specify. white Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Atomic physicist Research Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Giuseppe Giacchetti Adalgisa Ferri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paula Waldron - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven Memorial Department of H Important: If ite any injury or of 20c. Location - City or Town, State Date 1 XX urial 2 Cremation 3 Removal from State 1-4-2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph. sician disease or condition ongestive Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Due to (r consequence of Examir attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s performed 1 Yes 2 No certificate 1 ☐ Yes 2 🗷 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospita 1 \sum Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After this completely filled in by the funeral di 4 Nursing Home 5 X Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Z Natural work?
1 Yes 2 No 5 Pending iniury Investigation Accident М Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

Q

29b. Signatur

d title of certifier

Date filed (Month, Day, Year)

Shab

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Thomas

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 43406 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29, Physician/ David E. Gade 10:00 A M December 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 436 Girard Street, Apt. Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Month, Day, Year) une 3,1943 1 🛛 M 2 🗆 F Months Days Hours Min New York **Director** 219-42-2367 68 June Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Montgomery Gaithersburg 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 436 Girard Street Apt 3 20877 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Yes Give 1 ☐ Yes 2 💢 No White Specify: 3 Widowed 4 Divorced Completed Year or Dates. Vietnam the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Technician Orthopedics Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hugo W. Gade Evelyn Jagow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel W. Gade (Brother) 30 Harrington Terrace, Burlington, VT 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Desember 1 Alexandria, VA Crematory 21. Signature of Funeral Service Cicensee 22. Name and Address of Facility DeVol Funeral Home, DRACUA $\overline{\text{MO}}1117$ 10 East Deer Park Drive, Gaithersburg, MD 20877 The 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Lesstarthan 2 Months Physician/ disease or condition resulting in death) Atherosclerotic Coronary Artery Disease Medical Examiner Due to (or as a consequence of Less than 10 Years Hypertension Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Exami attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 X No 2 🗌 No 1 Yes To the Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural injury 5 Pending s after death.

I Director: Aft
d in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 7+1 3344 December 29, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month,

Day, Year)

2012

JAN 03

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

Alan Pollack, 1201 Seven Locks Road, Rockville, MD 20854

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Svadami arra 2011 MOOIG Medical 0100 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death Hdveny Mo.1 Grove Lersburg 20m0r9 If Under 1 Year If Under 24 Hrs. 48. Date of Birth 6. Sex **Funeral** 7. Age (In yrs. last birthda Birthplace (State or Foreign 8/02/1945 **Director** Nicaraqua 212-08-0958 1 □ M 2 💆 F 66 Usual Residence of Deceden 10a. State MD Director 10b. County Montgomery 10c. City, Town or Location
Germantown the Medical Examiner must be notified at 10d. Inside City Limits 28a-f 1 🗆 Yes 2 🏅 No ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20874 1Willow Spring USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1 X Yes 2 □ No Specif Nicaraguan "natural", Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed wh.. *al Hygiene. *ar than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Condominium Bldg. Custodian and 2 should be filed witl Health and Mental Hygier tem 27 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alvarez Francisca Guadamuz Eduarde traumatic nusbanc 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st
Department of Health a
Important: If item 27 is
any injury or other term Juan Carlos Fernandez/ 1 Willow Spring Ct. Germantown, Md 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 1/3/2012 Silver Spring, Md 4 Donation 5 Other (Special Signa f Funeral Ser PHILIPADS RIWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Onset and Death intracranial disease or condition massive hemorrhage Medical resulting in death) Due to (or as a consequence of) Examiner barach Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Blateral that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Intraparenchyma Division of Vital Records, P.O. Box 68760 the ding IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnand 5 Other (specify) in the past 12 months?

1 Yes 2 No ō Day Pregnant at time of death Month signed by the at the detached for 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown ving cause given in Part II. Other significant conditions contributing to death but not resulting in the 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform certificate ! Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other. 2 - No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred pt C/o headacher Staggerd coming out of boys and tell hitting her head (Month Day Year) □ Natural 5 Pending s after death. 2 Accident 2 No filled in by the Investigation 1120 AM 1 Yes 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Ratal Route Number, City or Town, State) Gaither 701 Russell AVC MD 2 determined building, etc. Gaithersburg ketorest mai within 24 hours a To the Funeral L -0 MD 20877 Medical 29a. Certifier ע Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) grels H72163 0-0, 12/25/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical City or Rockville, mD 20850 Mohammed Mehmood DO State JAN 04 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State o	f Maryla		artment of H		and M	ental Hy	giene	011	1.31.00
			Registrar 1. Decedent's Name (First, Mid	idle I act)			Cei	tificate of L	Jeatn	1	2. Date of Dea	Reg. No.	UII	43409
P	hysicia		Mabel M. Hughe	,							Month	Day	Year	3. Time of Death
	Medio Examir		4a. Facility Name (if not institut		eet and num	ber)		4b. City, Town, or	r Location o	f Death	Decem	ber 19, 20	II ity of Death	10:15 AM ^M
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	uneral	Г	5. Social Security Number	6. Sex			. last birthday)	If Under 1 Year Months Days	If Under 2		8. Date of Birt	h	9. Birth	place (State or Foreign
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the M	or 28 e not	<u> </u>	10e Street and Number		a II awa			10f. Zip Code			Т	10g. Citizen o	of What Cou	
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21215-0036 within 72 hours after death with the Maryland giene.	item Jer m	Ē	11. Marital Status	12	2. Was Dece	dent Ever in U	J.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Orig	jin? (Spec	ify Yes or No-		ace - Ameri	
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land be filed ental Hy	d oth	o Be	17. Father's Name (First, Middle	, Last)					18. Mothe	r's Name	(First, Middle,	Maiden Surnai	me)	
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Maryland 21215-0036 12 should be filed within 72 hours after alth and Mental Hygiene.	7 is n raum		19a. Informant's Name/Relatio	nship (Type	Print)			g Address (Street a				; City or Town,	State, Zip	
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imor Page 1 nent of	t: If it		1X Burial 2 Crematio	n 3 🗆 Re	moval from	State	-	natory or other plac			ate	20c. Location		
Baltimore, permit. Page 1 and Department of Hea	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Othe 21. Signature of Funeral Service	_				. Name and Addres			23, 2011	Mount S	avage A	Maryland
Balti permit. Departn	any		John 1	(4)	cirst	f	100	Durst Funer	,		rost Ave	Frostburg	z. MD 2	21532
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Phys	ician/		Shock, or heart failure. List Immediate Cause (Final disease or condition	t only one) Non	AM	Arten	0	25	21		- 5	Interval Between Onset and Death
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or y	erald	e: <u>1</u> 0	27. Manner of Death		28a. Date o	f injury	ER/Outpatien 28b. Time of	28c. Injury				ence 6 Ot)
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DIVISION OT all or Attending Pl	recto by th	Certificate:	3 Suicide 6 Cou 4 Homicide dete	d not be mined	28e. Place o	of Injury - At h	nome, farm, stre	et, factory, office		28			ber or Rura	l Route Number,
DIVISION OT VITAL HECC To the Hospital or Attending Physician: The law within 24 hours after death.	10 the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-transit			3							City or Tow			
Hosp 24 hor	Fune sted fi	edical	(Check 2/ Medica	Examiner	On the basis	s of examination	on and/or invest	ccured at the time, gation, in my opinio	n, death occ	curred at the	ne time, date ar	nd place, and d	ue to the ca	use(s) and manner stated.
o the	o the	Σ	only one) 3 Certifyi 29b. Signature and title of certifyi	ng Nurse P	ractioner: To	o the best of n	ny knowledge, d	eath occurred at the	time, date a	and place,	and due to the	cause(s) and r	nanner as st	ated.
_	3)	\sim)			_	1124	. 1	'	29d. Date sign	12	Day, Year) Di
)		30. Name and address of perso	n who com	oleted cause	of death (Ite	m 23a) (Type. P		114	7		14/1	4 15	· · · ·
)	roll !		Jesus Tan			,	ay Sti		rost	bur	g MD 2	21532		
	Stat	е	31. Date filed (Month, Day, Year)	111	32. Re	gistrar's Si g h								
R	egistra	ır	0L0 20 Z	711	Lene	a po.	(F							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle, Last) 2. Date of Death Physician/ 20/1 Month RYU 9400 3 Day Medical 4c. County of Death 4a. Facility Name (if not institution, give street 4b. City, Town, or L **Examiner** Suburba-25 565 el Qa 508261 Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreig)
 Country) **Funeral** Hours Min (Month, Day, Year, **Director** 213-27-7095 1 🗆 M 2 🕱 F 24 Dec. 29, Maryland Usual Residence of Deced 28a-f show 10a. State an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits irector 1 Yes 2X No Frederick Maryland Frederick ۵ 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21703 7016 Hames Court United States 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry oe filed with... ⊶al Hygiene. `oer than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Child Care Provider 12 Daycare traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 should be file in and Mental H is marked of ပ Annette Linton Jeffrey Harding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ye 1 and 2 s t of Health a 7016 Hames Court, Frederick, Maryland 21703 Annette Simanski/ Mother Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1
Burial 2
Cremation 3
Removal from State Stauffer Crematory Inc. 1/4/2012 Frederick, Maryland. 4 Donation 5 Other (Specify) 21. Signature of neral Service Lice Stauffer Funeral Homes. 1621 Oppossumtown Pike, P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Phy i i n Mas5100 disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed Exan and -tran that initiated events resulting in death) Last Due to (or as a consequence of) physician arest the burial-t Physician/Medical P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ P in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 , page performe certificate 2 🗌 No 1 🗌 Yes Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medica sion of Vital Be 26. Place of Death (Check only one) Hospital: Other: 1 🔀 Yes 2 No ဂ္ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred S/ 3/c veh/0/e 5 \square Pending ☐ Natural 2 Accident 1 ☐ Yes 2 📝 No Dec 30 201 Investigation 6 Could not be 1600 Trop 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ryral Route City or Town, State) determined Rock 8 24 hours a d Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifier -12 304 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Center Drive, Greenbelt, MD 20770 7523 Greenway Daee, MD, P.A. Said A. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Johanna Μ. van Heeckeren December 20 2011 3:30 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8115 Riverside Drive Cabin John Montgomery 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Feb. 12,1913 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 075-40-2197 98 **Director** 1 □ M 2 🗓 F Netherlands Usual Residence of Deced 28a-f shov aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ems 23a or 28a-f sh r must be notified a MD Cabin John Mongtomery 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8115 Riverside Drive 20818 Netherlands death v items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 X Widowed 4 □ Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jasper Boon Gasina van Groningen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8115 Riverside Drive, Cabin John, MD 20818 Adriaan C. Carter (grandson) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. Dato. ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 2011 Alexandria, VA 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee (M01116)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition et and Death Physician/ Pulmonary Embolism Minutes Medical resulting in death) Due to (or as a consequence of) Examiner Metastatic Breast Cancer Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ending physician and or use as the burial transit Exami or Attending Physician: The law requires that the death certificate be executed Dementia Years that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Year Pregnant at time of death should be detached g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performed? Yes 2 X No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No vithin 24 hours after death.

o the Funeral Director: After tompletely filled in by the funer. Certificate: 28d. Describe how injury occurred 5 Pending X Natural injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

State Registrar

0

30. Name and address of person who compl

Dr. Suhair H.

31. Date filed (Month, Day, Year)

eted cause of death (Item 23a) (Type, Print)

Abulfarag M.D.

D31391

604 South Frederick Ave. #413 Gaithersburg, MD.

December 21, 2011

20877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 5:30 am Grace Howe Hoy 2011 December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Hillhaven Assisted Living Facilities Prince George's Adelphi If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 431-82-5610 1 □ M 2 🗓 F 94 12/12/1917 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14725 Harvest Lane 20905 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No If Yes, Give 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Asian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Merchant 12 Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ျှ Chew How Lum Shee How 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14725 Harvest Lane, Silver Spring, Maryland 20905 Carmen Easley Hoy - Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🛱 Removal from State 4 🗋 Donation 5 🗆 Other (Specify) 01/03/2012 | Forrest City, Arkansas Forrest Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Cel 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the dise or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at only one cause on each line. Approximate Interval Between nset and Death Minutes Immediate Cause (Final Cardiac Arrythmia disease or condition resulting in death) Due to (or as a consequence of) 20 Years Coronary Artery Disease Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hypertensive Cardiovascular Disease 30 Years resulting in death) Last Left Ventricular Hypertrophy JE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 X No 9 Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Anemia, Cerebral Atherosclerosis, Senile Dementia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteoporosis, Osteoarthritis autopsy performed? Yes 2 X N 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Ph_sician/ Medical Examiner

Physician/

Medical

Examiner

Funeral Director

or 28a-f sl

items 23a or ner must be r

Examiner

0

"natural",

th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical |

item 27

Department of H Important: If ite any injury or ott

other

Funeral

or

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner been signed by the attending physician and should be detached for use as the burial transit Physician/Medical 2 Completed Be မ Certificate:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

24 hours after death. Funeral Director: After this certificate has

within 2

filled in by the funeral

Division of Vital Records, P.O. Box 68760

	1 Yes 2 X	No
27.	Manner of Death	
l	1 X Natural	5 🗌
ı	2 Accident	

3 Suicide 4 Homicide

Pending Investigation 6 Could not be determined

injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD: 20782

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

29c. License number

29d. Date signed (Month, Day, Year)

D17843

December 27. 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D

. C VIVEK 31. Date filed (Month, Day, Year)

Terrace, B102 Hyaltsville 3311 Toledo

DHMH 17 Rev 06-2011

Registrar

		for State Registrar	State of Maryl		tificate of i		-	Reg. No.		
Discolate		Decedent's Name (First, Middle, Las	t)				2. Date of De	eath	Vacu	3. Time of Death
Physicia Medic			ton Lee Hors	ey			Dec.	29°,	2011	7:35 а.м
Examin	er	4a. Facility Name (if not institution, give			4b. City, Town, c	r Location of Deat	h		unty of Death	
Francis	•	Maplewood Park I 5. Social Security Number 6. Se		rs. last birthday)	Bethes If Under 1 Year		8. Date of Bir		ontgome	ery place (State or Foreign
Funeral Director			□ M 2 x F 96	Yrs.	Months Days	Hours Min.	(Month, Da	8, 191	Coun	nsylvania
yland -f show ed at	Funeral Director	10a. State 10b. County	10c.	City, Town or Loc					1	0d. Inside City Limits 1 Yes 2 □ No
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eath v	-une	9707 01d Georget 11. Marital Status	12. Was Decedent Ever in	U.S. 13. V	20814 Vas Decedent of F	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No-		U.S.A Race - Americ	an Indian,
rs after death with the Maryland ural", or items 23a or 28a-f show Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Yes, specify Cuba		o Rican, etc.)		Black, White, e ecify: White	
n 72 hou an "natu Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		(Give A	lent's Usual Occup kind of work done O NOT use retired)	during most of wor	rking	16b. Kind	of Business Inc	lustry
withiir giene er th		Elementary/Seconday (0-12)	5+	Fo	reign Se	rvice Sp	ouse	U.S	S. Fore	ign Servi
filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surr	name)	
uld be Men narke natic	Ĕ	Joseph Jenkins L					uhn Har			
nd 2 shor salth and n 27 is n		19a. Informant's Name/Relationship (Ty Outerbridge Hor		19b. Mailin 1632 Wash	g Address <i>(Street</i> 32nd St nington,	and Number or Ru reet, N. D.C. 20	iral Route Numbe	er, City or Tow	vn, State, Zip C	;ode)
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	b. Place of Disposementery, creme St.	sition (Name of natory or other pla Mary s tery	^{œ)} Jan 2	uary 2, 012		ion - City or To ${ m sville}$,	
permit. Departr Import. any inji		21. Signature of Funeral Service Licens	# M00215	5 22	. Name and Addre	ess of Facility De				D.C. 20007
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icate be executed physician and sthe burial registrations.	a E	resulting in death) Last	Due to (or as a cons	sequence of):						
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	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No g ☐ Unknown	23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d	. Date of delive Month	ery Day Year
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ne law rec te has bee age 2 sho	Completed							psy ormed?	prior to cor death?	osy findings available mpletion of cause of
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hysic his ce I direc	၉	1 □ Yes 2 X No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	t 3 🗆 DOA Oth	er: 4 Nursing F	lome 512 Resi	dence 6 🗆	Other (Specify))
ling P	Certificate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year	28b. Time of injury	28c. Injur worl	ζ?	28d. Describe I	now injury oc	curred	
death ctor: /	tilic	2 Accident Investigation 3 Suicide 6 Could not be		t home farm stre		Yes 2 No	28f Location (Street and Nu	imber or Rural	Route Number,
ital or A urs after ral Direct		4 Homicide determined	building, etc. (Spe		et, factory, office		City or Tov		iniber of nurar	noute Number,
he Hosp in 24 hoi he Fune ipleted fi	Medical	(Check 2 Medical Exami	cician: To the best of my kn ner: On the basis of examinate Practioner: To the best o	ation and/or invest	igation, in my opini	on, death occurred	at the time, date a	and place, and	d due to the cau	use(s) and manner state
-		29b. Signature and title of certifier	. /11.	1-0 ~	29c. Licens	e number		29d. Date sig	gned (Month, L	Day, Year)
20		Jeny 14	www.	m45	D55	258		Decemb	er 29,	2011
		30. Name and address of person who c					M- 1	1 000	1.6	
Stat	e	Gary B. Wilks, M 31. Date filed (Month, Day, Year)	.D. 7758	Wisconsi	n Ave. B	ethesda,	Marylar	1d 208.	14	
Registra		JAN 03 2012	Sentia 1	and the second	1					

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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Medical Examiner	-	4a. Facility Name		give street and	d number)			4b. Ci	ty, Town, or	Location o	of Death	12			of Death		A
			nterloch	nen Dri	ve 1	[‡] 208			lver S			_]]	Mont	gome	ry	
Funeral Director		5. Social Security 200–24–		6. Sex 1 ▼ M 2 □	E		ast birthday Yrs.	/) If Uni	der 1 Year ns Days	If Under :	24 Hrs. Min.	8. Date of B (Month, D	irth a <i>y, Year)</i>			nplace (State or Fo ntry)	
		Usual Residence			79						1	12-17-	-193	2		Marylar	ad
f sho	5	10a. State	10b. County			10c. Cit	y, Town or	Location]	10d. Inside City L	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12 Physician/ 2011 Samuel Hanik 10:08 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5800 Nicholson Lane #903 Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Social Security Number Age (In yrs. last birthday) 9-5-191 Days Min 1 X M 2 □ I Director 100 215-38-3257 N.I Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1X☐ Yes 2 ☐ No MDMontgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5800 Nicholson Lane #903 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates.WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: "natural", 3 X Widowed 4 Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dentist Private Dental Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nathan Hanik Sarah Chonstovski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Hanik - Son 11820 Winterset Terrace, Potomac Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-22-2011 Olney, MD Judean Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction 3 1091 Rockville Pike, Rockville Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final I h sician/ disease or condition Medical resulting in death) Due to ur as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine i and To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗆 Yes 2 🗆 No 1 Matural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of D37840 December 21,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brent A. Berger, MD 10215 Femu Fernusod Road #50, Bethesda, UD 20817 Date filed (Month, Day, Year)

State

Registrar

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Physicia ledical Exami			RNARD	HINNANI,							2. Date of Dea Month December	Day r 30,		3. Time of Death 0050 hrs
		4a. Facility Name (Suburban H		on, give street and r	iumber)			City, Town, or ethesda	Location of	Death			c. County of Deat Montgomery	h
Funeral Director		5. Social Security P		6. Sex	7. Age (In 24	yrs. last birthday	_	Under 1 Yea Months Day		24Hrs. Min.	8. Date of Bir	,	7DD/YYYY) 9. Bi Forei	
409		Usual Residence o 10a. State	f Decedent 10b. County		10c	. City, Town or Le	ocation							10d. Inside City Limits
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eath with items 23	Funeral	11. Marital Status 1 X Never Marri	ed 2 M	larried Armed	ecedent Ever Forces? 2 X		Was De	ecedent of His specify Cubar	panic Origin , M exican, P	? (Spe uerto R	cify Yes or No lican, etc.)) -	14. Race - Amer White, etc.	ican Indian, Black,
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215- be filed ntal Hy rked of	a	Kevin Hi	nnant,	Sr.					Marle			Maraci	, Garrianne)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-7 sho injury or other traumatic event, the Medical Examiner must be notified at once.	٩	19a, Informant's Na Marlene											ity or Town, State , MD 207	
Ore, ges l and t of Heal			Cremation	n 3 Removal	from State	20b. Place of Dis	or other p	place)			Date		Location - City or	
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/Medical Examiner	Examiner	failure. List on Immediate Cause (or condition resultii Sequentially list co if any, leading to in cause. Enter Unde (Disease or injury t events resulting in	Final diseaseing in death) Inditions, inmediate erlying Cause hat initiated	3.4 14:1 1	a conseque	nce of):							- 21	Between Onset and Death
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physiciae: The law requires that the death certificate be exchin 24 hours after death. the Fluorial Director: After this certificate has been signed by the attending physician pletely filled in by the funeral director, page 2 should be detached for use as the burial.		IF FEMALE: 23b. Was decedent past 12 months	?	1 Live	nant at time	2 🗌	Fetal d	eath 3 [Ectopic p	regnand	су	23	d. Date of deliver Month	y Day Year
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Divisior Hospital or Attecd 24 hours after death Fuoeral Director: stely filled in by the	Certification:	3 Suicide 4 Homicide	6 Coul	ld not be 28e. Pla		At home, farm, t Road / Highw		ctory, office b	uilding, etc.		or Town, S	tate)		ral Route Number, City & Rt 97, Silver Spring
To the Hos within 24 ho To the Fuo completely	Medical (29a. Certifier (Check only one) 2		hysician: To the be miner:On the basis and manner	of examinat	-								
6	Me	29b. Signature and	20/4	the .	eek	300		29c. Licenso					Date signed (Mo	
		30. Name and addr Victor Weed		who completed cau Assistant M) W. B	altimore S	treet, Balt	imore	e, MD 2122	23		
Sta Regist	ate rar	31. Date filed (Mon	N 04	2012	tegistrar's Si	gnature	Wa	1.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND#10 cperFH, 1/5/12; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:24 pm Edward Henry 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomeru Carriage Hill Nursing Home Bethesda If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days **Director** 102-22-8780 1 X M 2 🗆 F 82 09/02/1929 New York Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Chevy Chase notified 1 Yes 2 X No Maryland Chava Montgomery 10f. Zip Code 10g. Citizen of What Country? must be I 23a 20815 u.s.A. 8100 Connecticut Avenue #1406 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ٥r Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify White 3 Widowed 4 Divorced if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Physician Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Sadye Walke Irving Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8100 Connecticut Avenue, Chave Chase, MD 20815 nt of Health a t: If item 27 is or other tra Sondra Henry - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Grdns 12/30/2011 Olney. Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MENINGIO MA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Ji g physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been sinced to the control of the cont Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3
Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Truong Bao, M.D.,

Mono, UND

10110 Molecular Drive

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00057124

#206, Rockville, Maryland 20850

12/29/11

Amer AACC	nd #1, 25 Health I	per Dept	. 12-28-11	Please KAH	Type or Po					a. Ensure A lealth and N				ible.	
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ng/Harry	Examin		4a. Facility Name (if	not institution, give)		4b. City, T		Location of Death		40	c. County Anne		
-	Funeral		5. Social Security No	umber 6. S	ex 7.7		ast birthday)	If Under		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)			place (State or Foreign
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9	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show , the Medical Examiner must be notified at	by Fur	11. Marital Status 1 ☐ Never Marr	ied 2 🗌 Married	12. Was Deceder Armed Forces 1 \(\subseteq \text{Yes} \) 2	2	L L	Was Decede f Yes, specif 1 ☐ Yes 2		spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	-	Blac	k, White,	can Indian, etc.
21215-0036	urs aft tural", al Exa	ted	3 🗌 Widowed		If Yes, Give Year or Dates							T	Specify:	W	nite
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and	be filed a ental Hyg ked oth c event,	To Be	17. Father's Name (First, Middle, Last) rt F. Dir	nklocker					18. Mother's Nam Elizak	ne <i>(First, Middl</i> e ceth Wi l			e)	
aryl	2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exa	- 3	19a. Informant's Na							and Number or Rui					
Σ,	E a a a		Kimberly 20a. Method of Disp		ı – Daugh					ord Drive					1 4 Town, State
Baltimore, Maryland	permit. Page 1 a Department of H Important: If ite any injury or oth		→ □ Burial 2	X Cremation 3	Removal from Sta	ite C	Place of Disponentery, cremetery, cremetery	natory or ot	her plac		Date 27-2011	1		-	Maryland
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Box 68760	the Hospital or Attending Physician: The law requires that the death certificate bein 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physicis impletely filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months? ☐ No	23c. If yes, outcor 1 Live Bir 4 Pregnar 9 Unknow	th 2 🗌 Fet nt at time of	al death 3	☐ Ectopic p☐ Other (sp		sy		m		ate of deli	very Day Year
P.O.	hat the des ed by the a detached i	y Phy	Part II. Other signi		contributing to deat	h but not res	sulting in the	underlying o	ause giv	ven in Part I.	23e. Did	tobacco	o use cont	tribute to	the cause of death?
	requires that i been signed b should be det	ed b									1 🗆	Yes	2 No	3 Pr	obably 4 🗆 Unknown
Division of Vital Records,	sician: The law requi certificate has been lirector, page 2 shoul	omple									24a. Was auto per 1 Yes	opsy formed?	,	prior to c death?	opsy findings available completion of cause of
talF	Physician: T r this certifica eral director, p	Be	25. Was case referr examiner?		Hospital:				26. Pl	ace of Death (Che	ck only one)				ghter's
of Vi	Physi r this c eral dir	e: 일	1 Yes 2		1 Inp	njury	ER/Outpatie		8c. Injun	y at	lome 5 Res 28d. Describe				Residence
ono	ending eath. or: Afte the fun	Certificate:	1 ₩ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigation 6 ☐ Could not	on	Day, Year)	injury	М	work 1 🗆	Yes 2 No					
Divisi	al or Attendi s after death. Il Director: A ed in by the fi	Certi	4 Homicide	determined	28e. Place of	Injury - At h etc. (Specif		reet, factory	, office		28f. Location City or To			er or Run	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check	Medical Exam	ysician: To the besi niner: On the basis rse Practitioner: To	of examination	on and/or inves	stigation, in r	my opinio	on, death occurred	at the time, date	e and pla	ice, and di	ie to the c	ause(s) and manner stated.
2.7	To the within To the comp	2	29b. Signature and		1 24	enta	e les								
	5,1		30. Name and add	ress of person who	completed cause of	of death (Iter	n 23a) (Type,	Print))./	Conce H	Lun A.	1010	Nal:	n W z	1 27'W11
	Sta		31. Date filed (Mon	th, Day, Year) DEC 2 8 2	011 32. Pg	istrar's Signa	ature	backs	104	Ense 17	my 11/10	IVN	1201 IS	71.0	461
	Registi	ar		720 % U L	LIE		14. 19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 9 2011 9:30 A M Edward A. Hayes Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel 219 Brownswood Rd. Annapolis If Under 1 Year | If Under 24 Hrs. . Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Hours 220-68-5374 Director 1X M 2 □ F 1959 Maryland 52 July 6 Usual Residence of Decedent show aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified Direct 28a-f Maryland Anne Arundel 1 ☐ Yes 2X No Annapolis 10e. Street and Number ori 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 219 Brownswood 21409 USA items 72 hours after death ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 2 y/s 739 = 11/20/79 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Divorced 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. the 1 12th Mechanic Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward A. Hayes Sr. Francis V. Stansbury 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenorise Johnson (Godmother) 1602 Agiate Ct. Annapolis, Md. 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State Maryland Veteran 12-19-11 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Wmame Research &cilitSons Mortuary, P.A. Larry S. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Corona Medical Due to (or as a conseque of): Examiner Sequentially list conditions, cause. Enter Underlying Exam Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the at the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certificate: To ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗌 this 27. Manner of Death s after death. I Director: After t 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Hospital Medical 29a Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 282011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1.3420 Reg. No. 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0247 HARRIGER ALFRED FRANK 12 201 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO Mediens MAINSULA ROGIONAL SAL 15641 Security Number 6 Sex Age (In vrs. last birthday If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day Year) Months Davs Country 184-34-9308 69 Director 1**X**] M 2 □ F APRIL 27, 1942 PA Usual Residence of Deced 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at 10b. County Director 1 Yes 2 X No MD WORCESTER BISHOPVILLE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ö or than "natural", or items 23a or the Medical Examiner must be Funeral 12048 SOUTH PINEY POINT ROAD 21813 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married q Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) ELECTRONICS SUPPLY VICE PRESIDENT 4 Be 17 Father's Name (First Middle Last 18, Mother's Name (First, Middle, Maiden Surname) should be file hand Mental F permit. Page 1 and 2 should be f. Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ ANNE FRANK GLENN HARRIGER LEE FRILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12048 SOUTH PINEY POINT RD., BISHOPVILLE, MD 21813 SHARON HUNT HARRIGER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 Dopation 5 Other (Specify) CREMATORY OF DELMARVA 1/1/2012 DELMAR, DE 22. Name and Address of Facility 21. Sign HASTINGS FUNERAL HOME, SELBYVILLE, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final with Recent MI Artu Disease Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner minth - 10 Suren Parks stenoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Day, Read Farly Aut Rud Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician sthe buria Pro Physician/Medical Yerra death certificate be Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Year Pregnant at time of death the the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b Q. S were colo Malling Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Atau Abdula 24a Was an page 2 s autopsy performed certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Yes ျှ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After 1
mpletely filled in by the funer 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2.

To the F
complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Des 12-31.201 DUN 069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAVIHOURY M 21804 10 1000 CINDICREM 101 31. Date filed (Month, Day, Year) Registrar's Signature JAN 0 4 2012 Barke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month G **Imes** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany WMHS-RMC Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday, **Funeral** Apr 6, 1962 Director 218-84-4859 1 XM 2 □ F 49 or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Allegany Cresaptown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21502 USA 12914 6th Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian "natural", or 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify. 3 Divorced white Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Alice May Kimble Benjamin Imes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co MD 21502 Connie Imes wife 12914 6th Avenue Cresaptown Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Glendale Cemetery 12/26/20 MD Donation 5 Other (Specify) Flintstone 22. Name and Address of Facility Scarpelli Funeral Home, PA Signature f Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ al herestentic rardiovax lan disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes 은 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D36766 December 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 Seton Drive Cumberland, MD 21502 Poonay M.D. Vikramaditya State Registrar

DHMH 17 Rev 06-2011

1-09722		Please Type or Print in Black Indelible Ink. E			jible.	
Roberta Leah J		1-For State Registrar Certificate of Deat		Re	g. No. 201	1 4342
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) Roberta Leah Jackson		Date of Death Month December	Day Year 27, 2011	3. Time of Death 1203 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, 3334 Sudlersville Road S Laure	Town, or Location of Death		4c. County of Death Anne Arundel	
Funeral Director		216-78-6021 1 M 2 XF 51 Yrs. Month	er 1 Year If Under 24Hrs as Days Hours Min.	-	h(MM/DD/YYYY) 9. Bir Foreig 5 / 1 9 6 0 Co	
with the Maryland nr 23a or 28a-f show any be notified at once.	Director	Usual Residence of Decedent 10a. State		10	g. Citizen of What Cour	10d. Inside City Limits 1 Yes 2 XNo
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, special Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	20724 ant of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto X No specify:		USA 14. Race - Ameri White, etc. Specify: Whit	can Indian, Black,
2	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) during most of wor 1 2 Hotel H	Occupation (Give kind of w king life. DO NOT use reting Bartender		16b. Kind of Business/I	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica	To Be Co	17. Father's Name (First, Middle, Last) Houston White 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address	18.Mother's Name Judy (Street and Number or F	y Willi	ams	, Zip Code)
		Darrell R Jackson Sr 3334 Suc	llersville	Rd S I	Laurel MD	
Page Page nent lant:		1 Burial 2 Xcremation 3 Removal from State crematory or other place; 4 Donation 5 Other Specify:	rem 1/	17/12	Glen Bu	rnie MD
Balt permit. Depart Import		21. Signature of Euneral Service Licensee 22. Name and Thomas	Address of Facility Sins AllenPA 70	nplicit 090 Ric	y Crem & dge Rd Hai	Fun Serv
Physician Medical Examiner		23a. Part I. Énter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	of dying, such as cardiac or			Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or input vibal immediate)				
ecuted and transit	ल	events resulting in death) Last Due to (or as a consequence of): dd	000 1 05 1			
50, te be ex hysician burial	Aedic	IF FEMALE: 23c. If yes, outcome of pregnancy	e,g923 1-25-1	2 sm	23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attendiog Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1	3 Ectopic pregna	ncy		ay Year
ords, P.O. E requires that the been signed by the	至	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	1 Yes	pacco use contribute to	ably 4 🗹 Unknown
Division of Vital Records, P.O. tal or Attendiog Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed			24a. Was a autops perform	y prior to c ned? death?	topsy findings available completion of cause of s 2 No
Of Vital Recion Physician: The l	o Be	examiner?	OA Other Nursing		Residence 6 🗸 Other	Scene
ion of Atending Ph.	ation: T		8c. Injury at Work?	28d. Describe he	ow injury occurred	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be determined Specify Found: Residence		S. Laui	cel,MD.	al Route Number, City ersville Rd.
To the Howithin 24 h To the Fu	Medical	Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.				
	We		O.C.M.E.		29d. Date signed (Mon	
pleand		 Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Stree 	t, Baltimore, MD 212	223		
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
DHMH 17 Rev 1/20	001	ORIGINAL		OCA	Æ.	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) r 25<u>, 2011</u> Physician 7:16 PM Patricia Marie Jones December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Leonardtown St. Mary's St. Mary's Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 👿 F 01-13-1939 217-38-8226 72 Maryland Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 1 ☐ Yes 2 XNo Lexington Park traumatic event, the Wedical Examiner must be notified Director MD St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ō United States 20653 45674 Summer Lane 23a Funeral items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 If Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 X No Specify: White ð 3 Widowed 4 XDivorced Year or Dates 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meas any injury or other traumatic event, the Meas Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wallace Reid Caldwell Helen Marie Olsen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2860 St. Leonard Rd., Port Republic, MD 20676 Bobby Reid Jones - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 12/27/11 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P. A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Minutes **Physician** FATSI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to initiations cause. Enter Underlying Cause (Disease or injury that initiated events COLDUNA nsequence of): requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the aid be detached for □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 3 ➤ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performe death? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of eath the funeral 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred I or Attending I after death. 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 10062893

DHMH 17 Rev 1/2001

State Registrar Michael

31. Date filed (Month, Day, Year)

JEW)

NO Box 524 Leonardtour, MA 20650

30. Name and address of pirson who completed duse of death (Item 23a) (Type, Print)

82. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Louise Jones 2011 2:32 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12419 Littleton Street Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral Davs Hours (Month, Day, Year) 578-24-5621 Director 1 M 2X F 88 Vrs Washington, DC April 18, 1923 28a-f show 10a. State 10h County 10d Inside City Limits must be notified at 10c. City. Town or Location Director 1 🗌 Yes 2 🔀 No MD Silver Spring Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12419 Littleton Street 20906 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Force Black White etc. 9 ģ 1 Never Married 2 Married 1 Yes 2 No SpecifyWhite Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify "natural", 3 Nidowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Secretary NIH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victor DeKalb Hickman Mary Elizabeth Hinwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Judith Leslie Jones/Daughter 12419 Littleton Street, Silver Spring, MD 20906 Dec 2011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 X Burial 2 Cremation 3 X Removal from State Lovettsville, VA 4 Donation 5 Other (Specify) Union Cemetery 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 1101503 500 University Blvd. W., Silver Spring, MD 20901 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Cardiac Arrhythmia Medical resulting in death) Due to (or as a consequence of Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) 2 Cause (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Generalized Arteriosclerosis Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2XXNo
9 Unknown Month Day Voar 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Hyperparathyroidism, S/P Parathyroidectomy 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate Yes 2X No 1 Yes 2 🗌 No Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 1 X Yes 2 □ No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5X Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural injury work? 1 Yes 2 No 5 Pending Director: A the f 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pletely filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Dopenlar 29 K 201 325410 30. Name and address of persowho completed cause of death (Item 23a) (Type, Print) #310 Oliver Lawless, MD 18111 Prince Philip Drive. Olney, MD 20832 31. Date filed (Month, Day, Year) State

Registrar

JAN 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dec Physician/ 0428 M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Med nne enter na 10 If Under 24 Hrs. Hours Min. Social Security Number 6. Sex . Age (In yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 926 Months Davs (Month, Day, Director Usual Residence of Decedent show 10a. State 10d. Inside City Limits 10c. City, Town or Location items 23a or 28a-f sho her must be notified at Director 1 Pyes 2 No thne's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral srave filed within 72 hours after death al Hygiene. I other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Baltimore, Maryland 21215-0036 Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 ₩idowed 4 Divorced Specify: Completed ack 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18 Mother's Name (First Middle Maiden Surname) 1 and 2 should be file of Health and Mental H item 27 is marked of မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) asonville 4 ☐ Donation 5 ☐ Other (Specify) Signatura of Funeral Service Licenses 22. Name and Address of Facility Home, P.A. Funeral Her washington Henry ambridge, STY 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such a ardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Physician/ disease or condition resulting in death) Medical Due to (c consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 1 🔀 Natural injury 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and of certifie 7 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | 43426 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0749 M THA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George 22920 Christ Church Road Aquasco 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Min 188-24-3149 Director 1 🗆 M 2 🗷 F 80 Vrs Pennsylvania 11, 1931 Usual Residence of Decedent show 10a. State 10c. City, Town or Location at Director r 28a-f sh notified a 1 Yes 2 No Maryland | Prince George Aquasco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral USA 20608 22920 Christ Church Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status rmed Forces? Black, White, etc. 1 Never Married 2 Married 0 þ within 72 hours after Baltimore. Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: White "natural". 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working tion life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) National Baptist Conven Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental ပ Marguerite Cochran Gerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois J. Johnson/Daughter 6 St. Anthonys Court, Stafford, VA 22556 and 2 s Health tem 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl
once. 1 Burial 2 T Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 12/28/2011 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home Funeral Service Ligens 21. Signatur Allen 2973 Solomons Island Rd. Edgewater, MD 21037 Part 1. Enter the disease, or contolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical law requires that the death certificate be IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 1 Live Birth 2 Live seasons 4 Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed' death? or Attending Physician: The 1 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 12 No ည 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun work? 1 Yes 2 No Division Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer D 21438 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Defense Hwy ANNAPALIS MO 21401 0. DEC 2 8 2011 State Registrar

DHMH 17 Rev 06-2011

Box 68760

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont December 26, 2011 Judy Irene Kirk 5:50 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 21317 Charlestown Road, SW Lonaconing Allegany 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 16, 1947 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country Maryland **Funeral** 1 □ M 2 🐹 F Days 219-52-0336 Yrs Director Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Allegany Lonaconing 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10a. Citizen of What Country? the Medical Examiner must be Funeral 23a 17316 Jackson Run Road 21539 USA items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ò þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾No Specify: "natural", Completed 3 Divorced 4 Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ew ပ Harold Lloyd Lashbaugh Leona Irene Merrbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Kirk - Husband 17316 Jackson Run Road, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cember 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory Cumberland, Maryland 4 Donation 5 Other (Specify) 27, 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Onser appleath Immediate Cause (Final Ph_sician/ 1 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death rate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an perform After this certificate 2 No Yes 1 Yes 25. Was case referred to edica Be 26. Place of Death (Check only one) 2 No Certificate: To 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manne of Death filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury 1 🔲 Yes o the Hospital or Attendithin 24 hours after death the Funeral Director: A 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ₩ Io 29b. Signature and title of certified 29d, Date signed (Month, Day, Year) 30. Name and address of person who comp ed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Dev. Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

To Be Completed by Funeral Director	1. Decedent's Nam Tamara K 4a. Facility Name (ii Hebrew F 5. Social Security N		Last)			ertificat					Reg. No	U. /		
dical liner al or	4a. Facility Name <i>(if</i> Hebrew H	Chamarme								2. Date of De	eath			3. Time of Death
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Director	Usual Residence of	Decedent						!						
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	21. Signature of Ju		tensee			22. Name a				Danzans				
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edic		8	d											
Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9	months?		Birth 2 🗆 nant at time	Fetal death	3 Ectopic 5 Other (s		су					ate of deli	very Day Year
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Completed					-					per 1 \(\sum \text{Yes}	formed?		death?	2 □ No
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욘	1 🗆 Yes 2	X No			2 ER/Outpa			4 10	1	ome 5 🗆 Res				fy)
Certificate:	27. Manner of Deat 1 Natural 2 Accident 3 Suicide	n 5 ☐ Pending Investiga 6 ☐ Could n	ation	of Injury oth, Day, Yea	28b. Time injur		28c. Injun work 1 🗆			28d. Describe	how inju	iry occurr	ed	
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Medical	(Check 2	Medical Ex	Physician: To the bacaminer: On the bacaminer: On the bacaminer:	sis of examin	nation and/or inv	vestigation, in	my opinio	on, death	occurred a	t the time, date	and plac	e, and du	e to the c	ause(s) and manner stated
	29b. Signature and	title of certifier	2				c. License					ate signe		, Day, Year)
	30. Name and addr		ho completed caus	se of death ((Item 23a) (Type Montro	e, Print)	al	D.	ock	011.) 2		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ P M2011 1:00 Yakov V. Kakitelashvili Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) **Director** 89 216-45-3799 1**X**□ M 2 □ F 7-15-1922 USSR Georgia 28a-f show 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 🔀 Yes 2 🗌 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 305 Redland Blvd. United States #202 20850 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 X Married ☐ Yes 2X☐ No Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: Specify: "natural", Completed 3 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Medical Doctor Surgeon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Veniamin Kakitelashvili Clara Kshondzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 602 Ridgemont Ave., Rockville, Maryland 20850 Vladimir Kakitelashvili -Son altimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Parklawn Cemetery 12-23-2011 Rockville, Maryland 21. Signature of Funeral Service Liçenses 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville Pike, Rockville Marland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a co Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a con: Due to (or as a consequence resulting in death) Last burialphysician s the burial Physician/Medical P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown s been signed by the should be detached Part II. Other significant conditions contribu ng to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. prior to completion of cause of death? autopsy 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No 1 X Inpatient 2 □ ည ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Etaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely fi. 29a, Certifier 3 Cer only one 29b. Signature and title 17005

State Registrar

JAN 03 DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

Ahmed Yehia Heshmat - 7133 Millrun Dr., Derwood, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 43431 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Raaret 12:40 A M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Orien Taneytown
Security Number 6. Sex Carrol laneytown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Hours Min Maryland 212-01-779 Yrs Director 4-17-1914 Usual Residence of Deceden 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No MD Carrol1 Westminster ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21157 USA 505 High Scre Drive #104 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner: Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 ₩ Widowed 4 □ Divorced Year or Date: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) secretar) steel company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Minnie Rose Reed George Raymond Eaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Weller Cir #324; Westminster, MD 21158 Barbara Sears - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Signature of Puneral Service Licen 22. Name and Address of Facility State Anatomy Board Ronald S 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Let the disease, ox omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Line of death Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 2 🗌 No 1 Tes 25. Was case referred to completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury death. 1 Ves 2 No ☐ Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Learnifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) H0061206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOBAL I RIHERA D. O. 688-C Poole Rd. Westminster 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 26 18 23 Physician/ Month Year David Ligay December 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical System Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours **Director** 051-36-7573 1 🗶 M 2 🗆 F Usual Residence of Decede 03-16-1946 New York 65 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Calvert Dunkirk 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 4230 Landing Lane 20754 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, and Mental Hygiene. is marked other than "natural", or iter aumatic event, the Medical Examiner. Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) P.G. Co. Government Medical Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewonce. ၉ Alexander Joseph Ligay A1ma Ballas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20754William H. Gilbert, Jr., Personal Representative, 4230 Landing Ln., Dunkirk, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-30-2011 Prince Frederick, MD John Vianney 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD M00715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ subdural Complications disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner GENTECKTION APPROVED BY MEDICAL EXAMINES Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury Exami this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Division of Vital Records, P.O. e Hospital or Attending Physician: The law requires that 24 hours after death.
Funcare Director. After this certificate has been signed theirly filled in by the funcari director, page 2 should be deteletely filled in by the funcari director, page 2 should be deteletely filled in by the funcari director, page 2 should be detered. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗶 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Yes 2 No ျှ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 03° AM 1 Yes 2 No December 24,2011 Investigation Fall down Stairs 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4230 Landing Home Lone Dunkirk, MD 207 Medical To the Hospi within 24 hou To the Funer completely fil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 48 December 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene St. Baltimore, MD 21201 MD 31. Date filed (Month, Day, Year) 32. Registra State

IAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar MEND#28e+fiperIME, 1/3/12; EWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) Arlene Sue 2. Date of Death 3. Time of Death LEHNER Physician/ 2011 6:03 AM December Medical 4b. City, Town, or Location of Death 01ney 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Montgomery General Hospital Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. Feb.14,1953 1 🗆 M 2 🗓 F 58 Harrisburg,PA 202-42-6252 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Silver Spring Director MD Montgomery 1 🗆 Yes 2 🗗 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 20904 3049 Memory Lane U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Writer B'nai Brith permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname)

Norothy Harris 17. Father's Name (First, Middle, Last) ٥. Pollack Dorothy Jerome 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheldon Lehner / spouse BO49 Memory Lane, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ (Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Garden Dec. 29, 2011 Olney, MD 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Solvice Lie 254 Carroll St., N.W., Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition mona Medical MIC resulting in death) Examiner a_{m} Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated as each of the conditions of the Examine Due to (or as a consequence of): B Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): 0 attending physician a for use as the burial-3 9 Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No After this certification 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 FR/Outpatient 3 DOA 28a. Date of injury (Month, Day,) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending n 24 hours after death.

le Funeral Director: A bleted filled in by the fu 200 1 Yes 2 To M Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Friend's residence 3 ☐ Suicide 4 ☐ Homicide 28f. **1303 (**Greek) Now I combat & Piliper Children State La., Silver Sp determined completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 10050910 30/11 and address of person who completed cause of death (Item 23a) (Type, Print) Philip, Olney 18101

State

Registrar

ed (Month, Day, Year)

JAN 03

2012

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 26 EDITH C. LANE 11:18 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince George's Regional Hospita .aurel -aure Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months SEPT 28 Hours Year) 942 578 56 0199 wash. Director 69 DC Usual Residence of Decedent show 10a. State with the Maryland 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director -28a-f DC WASHINGTON X☐ Yes 2 ☐ No 10e. Street and Number rms 23a or ò 10f. Zip Code 10g. Citizen of What Country? Funeral 1327 I STREET, 20002 USA N.E. be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural" Completed 3 Widowed 4 X Divorced SpecifBLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DC GOVERNMENT OF RECERTIFICATION Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ CALVIN LANE THELMA NICKENS permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST., N.W. WASH. DC 20001 ROBERTA COOPER/DAUGHTER 1622A 5th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2X Cremation 3 \square Removal from State RIVERDALE' PARKCE CŘEMATORY 1/4/12 RIVERDALE MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Honeral Service License 20010 22. Name and Address of Facility WATSON FH 3435 14th ST NW WASH. DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ HyperKalemia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to himselfat cause. Enter Underlying Examir Shoc Cause (Disease or iinjury that initiated events eptic attending physician Physician/Medical for þ Completed Certificate: To Be

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific

Baltimore, Maryland 21215-0036

obding in douth) East	Sepsis	
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year
Metabolic A		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
	iratory Failure	24a. Was an autopsy performed? 1 □ Yes 2 🔊 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 🔊 No
5. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DCA Other: 4 □ Nursing H	ome 5 Residence 6 Other (Specify)
7. Manner of Death 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	1 380 Place of Injune. At home form street feeten, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

aurel Regional Hospita

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiners On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

01296

December 27, 2011

7300 Van Dusen Road

Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier

(Check

Zorayda

29b. Signature and title of certifier

31. Date filed Month, Dav. Year

Lee-

JAN 03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lacer M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43435 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Edith m 126 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Iniversity of Maryland medical Social Security Number 6. Sex 7. Age (In yrs. Baltmore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Year) **Director** 579-56-3206 1 M 2 KF Washington, DC 67 05/23/44 or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10c. City, Town or Location 10d. Inside City Limits Director Md Prince George 1 Yes 2 No Oxon Hill 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 2414 W. 20745 Rosecroft USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pepco Meter Reader 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ James Brown Edith Selman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank K. Brown Son 5506 Joan Lane Temple Hill, Md 20748 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 01/06/12 Washington, DC Olive Μt 21. Signature of Funeral Service Licensee ින්ළෙස්ල් ^{Ad}f Wheral Home & Cremation 0777 5732 Georgia Ave NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Enterococca disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** relociuspiasti Sequentially list conditions, Due to (or as a consequence of): if any, leading to influediate cause. Enter Underlying Cause (Disease or injury Exami or Attending Physician: The law requires that the death certificate be executed after death. Clostridium and that initiated events resulting in death) Last Due to (or as a consequence of): burial physician by Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year signed by the at id be detached for 1 Yes 2.2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signe page 2 should be 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes ္ဝ 2 No 1 Nnpatient 2 🗆 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Moon MI 109301452 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. ionen E. Hona

State

Registrar

31. Date filed (Month, Day, Year)

JAN 04

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30. 2011 Bernard Yves Leprince December 1:30 pм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Wilson Health Care at Asbury Village Gaithersburg 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
July 20, 1926 **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) France 1X M 2 1 Hours 577-52-0155 85 Director Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f shorexaminer must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖾No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 333 Russell Avenue, Apt. 20877 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. White 1 Never Married 2 X Married 2 X No Completed by 1 ☐ Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: is marked other than "natural" 3 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Beauty Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andre Leprince Yvonne Charpentier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or 333 Russell Avenue, #522, Gaithersburg, MD 20877 Mary Rebecca Leprince/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ₭ Burial 2 ☐ Cremation 3 🗷 Removal from State Hillcrest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Louisa, 21. Sign ture of J 2. Name and Address of Facility rancis J. Collins Funeral Home Inc. O University Blvd. W., Silver Spring, Leteo MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inset and Death Immediate Cause (Final facture to This Physician/ One monto disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami and Hospital or Attending Physician: The law requires that the death certificate be executed Due to or as a consequence of attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown P.O. been signed by t should be detach Part II_A Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page After this certificate I funeral director, page 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the funeral processor. Accident Investigation 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

H. R. hert De

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (T

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2. Begistrar's Sign

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2011 10:09 P M Julius Mayo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) Dec 18, 1933 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Maryland Director 213-30-4528 1**X** M 2 □ F 77 23a or 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 N. Smallwood St; Apt 138 21223 USA items ? within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced If Yes Give Specify: black "natural", Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene, is marked other than Elementary/Secondary (0-12) College (104 or 5+) lab technician government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Smith Virginia Mayo other traumatic Page 1 and 2 should the ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) William Mayo - son 19b. Maijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3705 Evergreen Ave; Baltimore, MD 21206 Department of Health ar Important: If item 27 is any injury or other trauonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4X Donation 5 ☐ Other (Specify) Signature of Funeral Service Romal d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset a d Death Immediate Cause (Final Physician/ disease or condition resulting in death) a. Notastotic Medical as a consequence of Due to (or Examiner and the road self vite browns if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death detached g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has page 2 1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 흔 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27 Manner of Death 28a. Date of injury (Month, Day, Year) s after death. Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by ☐ Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Fune completely fi 29a. Certifier (Check only one) 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December 2011 2:25 A Doris Bissett Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Caribbean Breeze Assisted Living Calvert Huntingtown Social Security Number 6. Sex 1 ☐ M 2 💢 F 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New Jersey Hours 02-23-1925 Director 140-22-0677 86 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director or 28a-f 1 Yes 2 X No MD Calvert Dunkirk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 11711 Rivershore Drive 20754 USA items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married ò ☐ Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: Wh<u>ite</u> If Yes Give 'natural", 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ other traumatic Chester Η. Bissett Edith Hamilton Duren Department of Health and Important: If item 27 Is m any injury or other traumone. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles S. Martin III Son 11711 Rivershore Drive, Dunkirk, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 12-27-11 <u>Alexandria, VA</u> Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Lim M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FCURRENT disease or condition resulting in death) MUNTY Medical Due to (or as a consequence of) **Examiner** TRUKE Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) ng physician and as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown be detached ☐ Unknown P.0. signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 ☑ No 1 Tes Division of Vital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes Other: ဂ္ဂ 4 Nursing Home 5 Residence 6 X Other (Specify) Assisted 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Living Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide Could not be To the Hospital or Att within 24 hours after d To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D26358 address of person who completed cause of death (Item 23a) (Type, Print) 7H5 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Box 68760 death certificate be the attending physical of for use as the bu	Physicia	1 Yes 2 No 9 Unkr	100	ant at time of o	death 5	Othe	r (Specify)				1				
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Vital Rec ysician: The his certificate director, page		25. Was case referred to medical	T				26 Plac	ce of De	ath (Check		2 N	0 1	Yes	2	No
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Division of Vital Records, P.O. Box 68760, To the Haspital ar Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit.	Medical	(Check only	sician: To the best Iner:On the basis of	examination	dge, death and/or inv	occurred estigation	l at the time, o , in my opinio	date and n, death	d place, and n occurred a	I due to the ca at the time, dat	use(s) an e and pla	d manner as	stated to the	cause(s)	
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OCME	ŀ	30. Name and address of person w		•	,	-									
			Deputy Chief Me	edical Exa	miner	900 W	. Baltimor	e Stre	et, Baltir	more, MD 2	1223				
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regist	41	JANZ V6	UIC BOLLS	MN B	1 , 26,00	Chr. 20									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 43440 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month 1503 hrs December 30, 2011 Ali Christine Morrison 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's California If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Months Days Hours 1/7/1972 39 Country) DC 1 M 2 X F 577-86-4786 Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 Terrace Drive 20678 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2 X Married 2 X No 1 Yes 4 Divorced If Yes, Give Year White 1 Yes 2 No specify: Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Senate Doorkeeper U.S. Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert McGraw Karen Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terrace Drive, Rick Morrison/Husband Prince Frederick, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cem. 1/5/12 Suitland, MD Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Raymond-Wood F.H., P.A. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory alrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and Death a. Multiple Injuries Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Day 3 Ectopic pregnancy Year 2 past 12 months? Pregnant at time of death 5 | Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been s ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA After this 1 🗸 Yes funeral 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject driver struck guard rail Dec 30, 2011 1 Natural 1445 hrs 1 Yes 2 V No Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Rt. 4, California, MD determined (Specify) Local Street 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

dRW 2

31. Date filed (Month Jan Year) State Registrar

Victor Weedn MD JD

29b. Signature and title of certifie

ccl

32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

OCME

116

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

December 31, 2011

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25 Day MILLAN 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death ANNE ALLUDZ MEDICAL CANTER ANNAPOUS AUNE 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours 206-07-1231 Director 1 🕅 M 2 🗆 F 1/24/1918 93 PA 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 7020 Decoy Drive 20736 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed WW II White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Athletic Director High School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment.
Important: If item 27 is marked any injury or con-ည George Monchlovich Anie Gresomitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Millan/Daughter 1221 SW 114 st., Seattle, WA 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 \square Burial 2 X Cremation 3 \square Removal from State Chesapeake Crem. | 12/28/11 Belysville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) CONFERINE YEAR Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Exami and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician s should be detached for use as the burial-Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 3 ☐ Probably 4 ☐ Unknown Completed No Were autopsy findings available prior to completion of cause of death? 24a. Was an has te 2 autopsy s certificate has director, page 2 performe 1 🗌 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 1 Natural 2 Accident I Director: After the din by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after To the Funeral Director Completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year, 70865 death (Item 23a) (Type, Print) drw) ANNAPOUS

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 6:05PM Naomi Olsen Morley 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Solomons Calvert Solomons Nursing Center Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 147-32-4665 **Director** 1 🗆 M 2 😾 F 09/20/1922 New Jersey 89 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2🌠 No Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20685 United States 1913 Constitution Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Saltimore, Maryland 21215-0036 tem 27 is marked other than "natural", other traumatic event, the Medical Exar 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Operator Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry Olsen Louella Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl nt of Health a :: If item 27 is 1913 Constitution Drive, St. Leonard, MD 20685 Darryl Richard Morley / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or or 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/20/2011 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home. PA Kyle S. Simons M01206 4405 Broomes Island Road, Port Republic, MD 2067 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosciorotic Cardiovarculardisease disease or condition resulting in death) Medical **Examiner** Typertensive Cardio vascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hecur 1 Yes 2 No 3 Probably 4 Unknown Renal intubbiciency 24b. Were autopsy findings available prior to completion of cause of death? Chronic 24a. Was an has autopsy Fibrille Hou Atrial certificate 1 Yes 2 No Yes 2 X No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury ours after death.

leral Director: Aff
filled in by the fu Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 50653 12-19-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G MAN 0

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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	For State		State of M	arylan			Health and I	Mental Hy	giene 2	011	43443
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Medical Examiner			ive street and number)			4b. City, Town, or	r Location of Death			nty of Death	
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Funeral	5. Social Security		. Sex 7. Ag		as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 12/20/			hplace (State or Foreign (Tand
Director	218-12- Usual Residence		A	91	115.			12/20/	1920	mary	/Ialiu
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2 shouth and the shou			Daughter		1		and Number or Rui House Roa				MD 20615
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Page ment c ant: If ury or		2	Removal from State			natory or other place sland Cer	netery 12	2/23/11	Broome	es Is!	land, MD
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of F		- Jan	mu	22	. Name and Addres	ss of Facility Ra	usch Fu	neral I	Home.	PA.
0.0 = 0.0		S. Simo	ns M01206 Omplications that caused	d the death						epubli	ic, MD 20676
Dhysisian /	shock, or he	art failure. List onl	y one cause on each line	e. •			5251		rest,		Approximate Interval Between Onset and Death
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the at hed for hed for ysic	1 Yes 2	☐ No	4 ☐ Pregnant a g ☐ Unknown	t time of d	eath 5	Other (specify)				Month	Day Year
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The law require: cate has been signage 2 should be Completed	1							24a. Was			opsy findings available ompletion of cause of
The la								auto perfo 1 🗆 Yes	ormed?	death?	2 No
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ath.: After e fune	1 Natural 2 Accident	5 Pending	(Month, Da		injury	work		26d. Describe i	now injury occi	irred	
I or Attending Physician: after death. Director: After this certific i in by the funeral director, Certificate: To Be (3 D Suicide 4 D Homicide	6 Could no determine		ury - At ho	me, farm, stre	et, factory, office		28f. Location (S		nber or Run	al Route Number,
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but Medical Certificate: To Be Completed by Physician/Medical	(Check	2 Medical Exa	hysician: To the best of miner: On the basis of e	xamination	and/or invest	igation, in my opinio	on, death occurred a	at the time, date a	and place, and	due to the ca	ause(s) and manner stated.
To the within complete Complete N	only one) 29b. Signature and		urse Practioner: To the	best of my	knowleage, a	29c. License		ce, and due to th	29d. Date sign		
	1 h	antul	Jull	/	40	\mathcal{D}	70851		12	120/1	1
() ()	30. Name and add	ress of person wh	o completed cause of d	eath (Item	23a) (Type, P	rint) Panai		redoni	N. M		201076
State	31. Date filed (Mor	nth, Day, Year)	32. Registra	S Signatur	JV (TCC	Kala	THILL	YCULLY)	MILL	ر ال	20410
State Registrar			21 2011	neva	1 1.	barker),				

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			1. Decedent's Name (First, Middle, L	ast)		Cer	unca	e or L	Jean		2. Date of De	Reg. N	lo. / U		3. Time of Death
	Physicia Medic		James Wyatt Moo	re, Sr.							$\overset{Month}{12}$	29 D	² 2011	Year	2:25 A M
	Examir		4a. Facility Name (if not institution, gi				4b. City	, Town, o	r Location	of Death		4	c. County o	f Deat	h
1			Laurelwood Care 5. Social Security Number 6.			- 4 t- : 1 1 1		kton	If Under	r 24 Шrs T	0 Data + 6 Di		Ceci	_	halas Ottoba a Familia
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36	after al", or Exami	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No				Specify				Specify:		White
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Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship			19b. Mailir	ng Addres	ss (Street			Route Numb			ite, Zip	Code)
Σ	e 1 and 2 s of Health If item 27 i or other tra		Janie P. Moore	- wife		691	Eng1	and	Cream	ery l	Road, 1	Nort	h Eas	t,	MD 21901
Baltimore,	m		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State		lace of Dispo emetery, cren	sition (Na natory or	me of other plac	ce)		ate)	20c.	Location - 0	City or	Town, State
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	_		23a Part 1. Enter the disease, or co shock, or the art failure. List only Immediate Cause (Final	mplications that cause	d the death	n. Do not ente	er the mo	de of dyin	ig, such as	cardiac o	r respiratory a	rrest,	Duity		Approximate
7.14	Physician/		Immediate Cause (Final disease or condition	Cons	ent:	re H.	ear	1+	Fai	lur	e.				Interval Between Onset and Death
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		ē	Sequentially list conditions,	b. Athe.			200	19	`						20 years
	ted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Duo te (oi ao	a consequ	c1100 01j.									
	ath certificate be executed attending physician and for use as the burial-transit	I —	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):									
09	Attending Physician: The law requires that the death certificate be or death. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bu	Physician/Medica		d										\dashv	
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Vita	Physicia this cerr al direct	10 B	examiner? 1 Yes 2 No	Hospital:	ient 2 🗆	ER/Outpatier	nt 3 🗆 🗆	Oth			me 5 🗆 Res	idence	6 🗆 Other	(Spec	ify)
of	Attending Physician: er death. ector. After this certific by the funeral director,	ate:	27. Manner of Death 1 ☑ Natural 5 □ Pending	28a. Date of inju (Month, Da		28b. Time of injury		28c. Injur work	y at </td <td>2</td> <td>28d. Describe</td> <td></td> <td></td> <td></td> <td></td>	2	28d. Describe				
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Division of Vital Records,	Il or A after Direc d in by		4 🗌 Homicide determine	d building, et			et, lactor	ry, onice		ľ	City or To			or Hu	ral Route Number,
-	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical		ysician: To the best of											ited. cause(s) and manner stated.
	the H thin 24 the F	Me	only one) 3 Certifying N	rse Practioner: To the			death occi	urred at th	e time, dat			he cause	e(s) and man	ner as	stated.
	6 ≥ 6 0		29b. Signature and title of certifier	10					65°0	12		29d. D	ate signed	Month	n, Day, Year)
			30. Name and address of person who	completed cause of c	leath (Item	23a) (Type, F			65 U	17		, 4	170	10	/ '!
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/Medi Examir		George M. Miller 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc		December	4c. County of Dear	h	
uneral	*	187 M 20 F	(In yrs. last birthday)	If Under 1 Year if	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 13	Q Rin	ontgomery hplace (State or Foreign untry)	
)irector ≥		Usual Residence of Decedent 10a. State 10b. County	68 Yrs.	cation		March 13	, 1943 wa	Shington, DC	
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Department or nealin and wenter riggene. The partment or nealin and wenter riggene. The many injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 11 ☑ Never Married 2 ☐ Married 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates;	0	Was Decedent of Hispa If Yes, specify Cuban, N 1 ☐ Yes 2 <mark></mark> Mo <i>S</i>	inic Origin? (Sp Mexican, Puerto pecify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:		
"natural" edical Ex		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of work	6b. Kind of Business			
Hyglene. ther than nt, the M	Completed	Elementary/Secondary (0-12) College (1-4or 5-1) 17. Father's Name (First, Middle, Last)	F)	rical Offic	NT l	Н			
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aun and 127 is m er traum		19a. Informant's Name/Relationship (Type. Print) Susan Miller Soulé - Sister	I	ng Address (Street and 8 Walnut Co			-		
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Importa any Inju		21. Signature of Funeral Service Licensee	22		f Facility His	res-Rinal	di Funera	l Home, Inc.	
		23a. P rt1. Enter the dise, se, or complications that caused shock, or heart failure. List only one cause on each line immediate Cause (Final	the death. Do not ent	er the mode of dying, s	uch as cardiac			Approximate Interval Between Onset and Death	
ysician ledical aminer			consequence of):	h Metastasi	<u>.s</u>				
Ξ Ω.	Examiner	cause. Enter Underlying Cause (Disease or injury	consequence of):						
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ling phys e as the	Medical	IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery							
y the attending packed for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			ive ry Day Year		
n signed buld be deta	by	Part II. Other significant conditions contributing to death but	t not resulting in the ur	nderlying cause given ir	n Part I.	23e. Did tob	acco use contribute to s 2 □ No 3 □ Pi	o the cause of death?	
Table 12 rough and organic and the fundamental director, page 2 should be detached completely filled in by the funeral director, page 2 should be detached	Completed					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of	
certifica rector, p	Be	25. Was case referred to medical examiner?		Other:		h (Check only one)		
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Director:	Certification:	2 Pulalda 6 Could not be	ry - At home, farm, str . (Specify)			28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,	
Funeral etely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best or 2 Medical Examiner: On the basis of and manner stat	examination and/or in						
1 de 10	Me	29b. Signature and title of certifier	CIM	29c. License nu			29d. Date signed (Month, Day, Year)		
		30. Name and address of person who completed cause of de		Print)	0006243		Tanuary 02		
C+	to	Sayed Elsayyad, M.D., 10110 31. Date filed (Month, Day, Year) 32. Registrar	Molecula r's Signature	r Drive, F	Rockvil	le, Maryl	20850		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Curtis Lionell Martin 1720 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Kehabilitation and Nursing pring Contgane 9. Birthplace (State or Foreign Country) Michigan Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours (Month Day, Year) 932 **Director** 250-46-2003 Usual Residence of Decedent 28a-f show with the Maryland 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 18735 Brooke Road 20860 u.s.A. permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. African-American 1 ☑ Yes 2 ☐ No 1953-If Yes, Give δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Completed 3 Widowed 4 Divorced 1956 Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Department of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Lee Harper Wright Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Sandra Martin/Spouse 18735 Brooke Road, Sandy Spring, Maryland 20860 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ↑ ↑ Lincoln Crematory 01/09/2012 | Brentwood, Maryland 21. Signs ur of Fu 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. <u> 11800 New Hampshire Ave., Silver Spring, MD 20904</u> 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ montas disease or condition Medical resulting in death) Due to (or as a consequen : of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year g Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by gastroe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes ည Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident

Accident

Suicide

Homicide 1 🗌 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10+1 dress of person who completed cause of death (Item 23a) (Type, Print) Brooketh Hman, M.D. 18100 Slade School &

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:53 рм December Ruth Marenus Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Nous Varia **Funeral** Days (Month, Day, Year) 10/18/1915 1 M 2 X F 135-01-0892 96 New York Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Chevy Chase 1 Yes 2 X No Maruland Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 5555 Friendship Blvd., Room 226 20815 U.S.A 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 □ Divorced Caucasian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) other than life. DO NOT use retired) Claim Supervisor & Administrator Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Administration 27 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David Wasserman Sarah Solomon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5406 Surrey Street, Chevy Chase, Maryland 20815 Barbara Marenus - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Burial 2 Cremation 3 12 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lebanon Cemetery 01/03/2012 Iselin. New Jersey 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease shock, or heart failure. L or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 3 Days Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Examiner Atherosclerotic Coronary Artery Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Day 2 X No 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, Acute Renal Failure 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performed Yes 2 X No 1 🗌 Yes 2 🗌 No 25. Was case referred to medica of Vital 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Hospital Other: ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA _4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier comas D50534 December 31, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6858 Old Dominion Drive. #104. McLean, Virginia 22101 Thomas Masterson. M.D. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month P^{M} December 2011 Anna Talbert Mistretta 5:55 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Solomons The Hermitage Calvert . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Months Hours (Month, Day, Year) 577-01-4114 1 🗆 M 2 🗶 F 97 9/7/1914 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland| Prince George's Temple Hills 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2706 Frazier Drive 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕍 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Herbert Talbert Sallie Ann Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2710 Frazier Drive, Temple Hills, MD Anna Marie Lenck/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cem. 1/5/2012 Suitland, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home Service Licensee 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Htheroscieno Cardio Vasular disecos disease or condition resulting in death) Hupertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23d. Date of delivery Month Dav Year

Physician/ Medical **Examiner**

Physician/

Medical

10a. State

Examiner

Funeral

Director

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Department of Important: If it any injury or o once.

Medical

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21. Signatur

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Page 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran attending physician ed by the a detached t s been signed by the should be detach has this nours after death.

neral Director: After the filled in by the funera within 24 hours after d

To the Funeral Direct

completely filled in by

The law requires that the death certificate be

To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760

Physician/Medical

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Certificate: To Be Completed

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c, If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	3						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dionetes mellitus Type Two								
Periphera	1 Asterial	disease						

23e. Did tobac	co use cont	tribute to the cau	se of death?
1 🗌 Yes	2 No	3 Probably	4 🗌 Unknow
24a. Was an autopsy	24b.	Were autopsy fin prior to completi	dings available on of cause of

·		performed? death? 1 \sum Yes 2 \sum No 1 \sum Yes 2 \sum No
25. Was case referred to medical examiner?	26. Place of Deat	th (Check only one)
1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nu	ursing Home 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigatio 3 □ Suicide 6 □ Could not be	28a. Date of injury (Month, Day, Year) n	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	1 A Certifying	Physician: To the best of my knowledge, death occu	rred at the time, date and place, and due to the	cause(s) and manner as stated.
(Check	2 Medical Ex	xaminer: On the basis of examination and/or investigati	on, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner state
only one)	3 Certifying	Nurse Practitioner: To the best of my knowledge, dea	th occurred at the time, date and place, and due to	the cause(s) and manner as stated.
29b. Signature ar	d title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

Manual address of person who completed cause of death (Item 23a) (Type, Print) GVAN C. SURANA

5851: Daniel 2

Deale

State JAN 0 4 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland State of Maryland		nent of Hea ate of Dea			ene 201	1 43449	
	Physicia Medi		Decedent's Name (First, Middle, Last) Mary Alice Miller				2. Date of Death	. 29, 2011	3. Time of Death 5:15 p M	
-	Examir —		4a. Facility Name (if not institution, give street and number) 1908 Kipling Drive 5. Social Security Number 6. Sex 7. Age (in vrs. la.)		City, Town, or Loca Salisbur nder 1 Year If U		Wicomico			
To the second	Funeral Director		070-26-6604 Usual Residence of Decedent 1 □ M 2 🖾 F 78	Yrs. Mon		ours Min.	8. Date of Birth (Month, Day, Ye 10/07/19	ear) Cou	hplace (State or Foreign intry) W York	
:	or 28a-f sh	Funeral Director		Salisbury	. Zip Code		1.0	g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	ns 23a o	neral	1908 Kipling Drive		21801		100	USA	untry?	
9800	permit. Fage I and 2 should be hied within 72 hours after death with the Mayland hoperarment of Health and Mental Hygiene. Important if fire It is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	If Yes,	ecedent of Hispan specify Cuban, Me es 2 X No Sp		cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh		
Baltimore, Maryland 21215-0036	within 72 ho giene. ier than "na t, the Medic.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4+	16a. Decedent's (Give kind of life. DO NOT Teach e	work done during use retired)	g most of workin	ng	Education	ndustry	
land	fental Hy rked oth	To Be	17. Father's Name (First, Middle, Last) William Ellis			Mother's Name Jeona A	(First, Middle, Mai L len	den Surname)		
, Mary	nd z snould ealth and N m 27 is ma ier traumai		19a. Informant's Name/Relationship (Type, Print) Walter Miller/Son	19b. Mailing Add	ress (Street and N Governor	lumber or Rural Dr., N	Route Number Ci New Port	ty or Town, State, Zip, News, VA	23602	
timore	L. Fage I a tment of H tant: If itel ijury or oth		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ace of Disposition metery, crematory isbury C	or other place)	1		c. Location - City or 1		
Bal	Depar Impor any in		21. Signature of Funeral Servi Licensee	行め17 501	oway Ful Snow Hil	feral Ho	me Profe Salisbur	ssional As y, MD 2180	ssociation 04	
ا	n sician/ Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause. Finite in a conseque Cause. Finite in a conseque Cause. Finite in a conseque Cause. Finite in a conseque Cause. Finite in a conseque Cause. Finite in a conseque Cause. Finite in a conseque Cause. Finite in a conseque Cause.	ion ence of):	node of dying, suc	ch as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death	
68760 certificate be executed	rysiciar he buri	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Hyperlipic Due to (or as a conseque d.							
Box death	ne attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【 No g ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal of 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ector	oic pregnancy (specify)			23d. Date of deliv	very Day Year	
s, P.O.	signed b	ρ	Part II. Other significant conditions contributing to death but not result	ting in the underlyi	ng cause given in	Part I.		co use contribute to t	he cause of death?	
Records, The law requires	ate has page 2	Completed					24a. Was an autopsy performed	24b. Were auto prior to co	opsy findings available ompletion of cause of	
Vital ysician:	s certific director,		25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 El	P/Outpatient 3	Other	Death (Check of	only one)	e 6 Other (Specifi		
DIVISION OT VITAI RE To the Hospital or Attending Physician: The	within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certificate: 1	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28	Bd. Describe how in		//	
UIVISI tal or Att	rs after d al Direct		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, fac	tory, office	2	Bf. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,	
the Hospi	thin 24 hou the Funer mpletely fill	Med	29a. Certifier (Check 2 Medical Examiner: On the best of my knowled only one) 3 Certifying Nurse Practitioner: To the best of my	and/or investigation, knowledge, death	in my opinion, dea occurred at the time	ath occurred at the e, date and place	ne time date and ni	are and due to the ca	use(s) and manner stated	
			29b. Signature and title of certifier		29c. License numb	712		Date signed (Month,		
(510		30. Name and address of person who completed cause of death (Item 2:	(3a) (Type, Print)	+ 54	5046 -	Colishus	2-30-301. 4 MD.	21804	
u	State Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	1. par	1			<i>j</i> , , , , , , , , , , , , , , , , , , ,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) December Physician/ 28, 2011 2315 Ndikumana Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) 1 🗓 M 2 🗆 F 217-67-7312 Director Yrs June 15, 1954 Burundi 57 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shou ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County Director 1 😾 Yes 2 🗌 No MD Montgomery Gaithersburg 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number Funeral 20878 Burundi 9904 Shelburne Terrace, #307 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) World Bank Consultant 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Joseph Simbaruhije Generose Boyayo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9904 Shelburne Terr. #307, Gaithersburg, MD 20878 Linda Ndikumana / Daughter 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/05/2012 Burundi Cimetiere de Mpanda 21. Signature of Funeral Service Licensee Name and Address of Facility Thibadeau Mortuary Service, p.a. M00956 7 Park Avenue, Gaithershurg 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NON-TRAUMATIC INTRACRANIAL HEMORRHAGE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** HYPERTENTION countielly list our ditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 3 requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? for Year Month Day Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.
To the Funeral Director: After this certificate has t gompletely filled in by the funeral director, page 2.8 autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No မြ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending work Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

D67986

DECEMBER 30, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 OLD GEORGETOWN ROAD, BETHESDA, MD 20814 YUNENG LI, M.D.,

State Registrar

Medical

31. Date filed (Month, Day, Year)

JAN 03 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:41 P M Lee Charles Nhare December 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours **Director** 032-22-9083 1 X M 2 - F May 4, 1929 New York Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Marvland Edgewater Anne Arundel 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral USA 827 Mayo Road, Apt. 15 21037 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or iter Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Bus Driver Transportation 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Davis Nhare unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 827 Mayo Road, Apt. 8, Edgewater, Maryland 21037 Terri L. Russell/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Edgewater, Maryland Kalas Crematory 12/28/11 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signat of Funeral Service License 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LAYONG Ph_sician/ disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this continue has a continue to the funeral Director. the burial-tran resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 은 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No 100 P Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Deput and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

DEC 282011

ones

32. Registrar's Signature

695 AMERICA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gordon James Opel Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western MD Regional Medical Center Allegany Cumberland 7. Age (In vrs. last birthday) If Under 1 Year If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) **Director** 1 **X** M 2 □ F 58 January 29, 1953 Ohio 28a-f show 10a. State 10c. City, Town or Location Examiner must be notified at 10b. County Director Allegany Midlothian Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20115 Old Midlothian Road items 23a Funeral 21543-U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates White or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Heavy Equipment Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Russell J. Opel Charlotte Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Jean Opel wife Maryland 20115 Old Midlothian Road Midlothian 20a. Method of Disposition
1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date injury o 4 Donation 5 Other (Specify) Cumberland Crematory December 24, 2011 Cumberland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility any Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mmenar Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director. After this certificate h completely filled in by the funeral director, page 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🗖 No Hospital 1 Yes မ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pendina 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Kohet Jam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Combinand 21502 Road 12500 Willow brook MIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

10d. Inside City Limits

21543-

Approximate Interval Between

DOVS

Onset and Death

Year

Day

Maryland

1 🗌 Yes 2 🗶 No

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43453 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year OHN 9:29 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12515 Canfield Lane Bowie Prince George's Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 104-30-4698 1**X** M 2 □ F 71 3/10/1940 New York Usual Residence of Decede 10a. State with the Maryland notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland| 1 X Yes 2 No Prince George's Bowie 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g, Citizen of What Country? Funeral 12515 Canfield Lane 20715 S. A. death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 X Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced "natural" Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) NASA Systems Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John O'Neill Mary Zaglauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes M. O'Neill / Wife 12515 Canfield Lane, Bowie, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Church 12/27/2011 Bowie, Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home, 21. Signature of Funeral Service Licensee 10= 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Profit and Death S my ornupitio Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, trans, searing to in receive cause. Enter Underlying Due to for as a sunbequence of,: Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and -tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Hospital: 2 1100 Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of centific pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **DEC 2 8 2011** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 43454 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 20 December 2011 Brenda Dixon 4:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Director 220-38-9354 1 □ M 2 🗓 F Usual Residence of Decede 70 09-24-1941 Maryland 28a-f show 10a. State Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD Anne Arundel Lothian 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a 6027 Fishers Station Road 20711 permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", Completed 3 X Widowed 4 Divorced Specify: White and Mental Hygiene.
Is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sewell Wilbur Sr. Dixon, Mary Agnes Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Dale P. Clark Daughter 1512 Vicoli Court, Severn, MD 21144 20a. Method of Disposition
1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Smithville Cemetery 12-23-2011 Dunkirk, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, William 1 50 M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the depth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ for in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death be detached the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available 24a. Was an this certificate has ral director, page 2 auto prior to completion of cause of death? performed Yes 2 accestous 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? niner? ျှ 2 🗌 No Other: 1 Nupatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 📈 No Natural 5 Pending injury Fractured 2/14/ r211 4 11 UNK M Accident Suicide the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Cente Medical Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check To the I within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nd title of certifier 30. Name and address of person who completed cause of death (Item 2 a) (Type, Print) 2001

Registrar

DHMH 17 Rev 06-2011

State

Judy Joseph-Herbert

31. Date filed (Month, Day, Year)

32. Registra s Signature

Registra

DEC 27

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Palin William Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS-RMC Allegany Cumberland 6. Sex 9. Birthplace (State or Foreign **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthpiac Country) PA Feb 9, 1921 206-03-6903 Usual Residence of Decedent Director 1 🛣 M 2 🗆 F 90 10a. State 10b. County at 10c, City, Town or Location 10d. Inside City Limits Director notified PA **Bedford** Bedford Twp. 28a-f 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? traumatic event, the Medical Examiner must be 23a by Funeral 1225 Cumberland Road 15522 USA or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 X Married Black, White, etc. within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ϊ No Specify: If Yes Give "natural", Specify: 3 Widowed 4 Divorced WW II Completed Year or Dates. white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) General Surgeon Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Anna Shaw John S. Palin 1 and 2 should by Health and Mei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn O'Neal 2609 Shoal Place AL35473 daughter Northport injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 12/26/201 Palin Family Cemetery PA 4 ☐ Donation 5 ☐ Other (Specify) Bedford 22. Name and Address of Facility
Scarpelli Funeral Home, PA Signature of Freal Se 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Examiner Se wentially list conditions Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) the g Unknown g Unknown detach þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available has e 2 prior to completion of cause of death?

1 Yes 2 No page 2 performed? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death I Director: After the funeration by the funeration Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely for 29b. Signatura and title of certifier 10 patr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m.r 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #5 Per FH G924 2/03/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John 9:07 A M Forrest Peacock 2011 Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4h City Town, or Location of Death 4c. County of Death Smith Creek Assisted Living Warwick Cecil Social Security Nur 8791 If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) North Carolina 8. Date of Birth 550-52-8741 1 **X** M 2 □ F Months Days Hours Min Director Usual Residence of Decedent show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Cecil Elkton or 28a-f 1 🗌 Yes 2 💢 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 31 Sparrows Way 21921 USA items be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No ō Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural", 3 Ulidowed 4 K Divorced ortant; If item 27 is marked other than "natur injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Animal Medicine Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha Elementary/Seconday (0-12) College (1-4 or 5+) Veterinarian 12 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Roy Peacock Sr. Mary B. Forrest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lindsay S. Peacock / daughter 326 Frenchtown Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important; If ite
any injury or ot 20c. Location - City or Town, State United Crematory or other place 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State 01/05/2012 Newark, DE 4 ☐ Donation 5 ☐ Other (Specify) Services Strano & Feeley Family Funeral 635 Churchmans Road, Newark DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Bath 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ been signed by the atte should be detached for in the past 12 months? Pregnant at time of death Unknown Month Day Year Yes 2 No g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed Yes 2 certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Tyes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce

State Registrar 30. Name and address of person

31. Date filed (Month

RI

who completed cause of death (Item 23a) (Type, Print)

	Plea	ase Type or	Prin	nt in E	Black II	ndelib	le Ink	k. Ens	ure A	II Copie	s	Are Leg	ible.			
For					d / Dep	artmer	nt of H	lealth		nental Hy)	43458		
State Registrar					Ce	rtificat	e of D	eath			Reg	g. No.	7 1 1	70700		
1. Decedent's Name	e (First, Middle	e, Last)								2. Date of De	eath	Day	Vaav	3. Time of Death		
	DE	EONARAIN		PI	ERSAUD)				DEC.		28 , 2	2011	4:25 P ^M		
4a. Facility Name (if	not institution	n, give street and nur	nber)			4b. City,	Town, or	Location	of Death			4c. County	of Death			
SHADY	GROVE	ADVENTIST	HOS	SPITA	L		ROCK	VILL	E	MONTGOM				ERY		
5. Social Security Nu		6. Sex	7. Age	(In yrs. la	st birthday)	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Bi		ear)		irthplace (State or Foreign country)		
577-21-		1 🗓 M 2 🗆 F		69	Yrs.		World S Days Hours Will.			MARCH				GUYANA		
Usual Residence of 10a. State	10b. County		-		, Town or Lo	cation				THIRTOIL		, - , -		10d. Inside City Limits		
	MONTE	COMPA		1001 011)	, 101111 01 20		ם מדי	DING					- 1	1 X Yes 2 No		
MD . 10e. Street and Num		GOMERY				SILVE 10f. Zip		KING			40	- 01111	A/h a h O -			
		יייי איז אייי	6			101. 21		06			10g, Citizen of What Country? GUYANA					
11. Marital Status	HEWII	T AVE. #7		or in LIS	12	Mas Doce	209		igin? (Spe	oify Vac or No.						
Never Marri	ed 2. ▼ Mar	Armed Fo	orces?		. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.										
3 Widowed		If Voc Gir	ve	NO	1 ☐ Yes 2 ☒ No Specify:						Specify: EAST INDIAN					
(Spe		nt's Education est grade completed	r)		(Give	6a. Decedent's Usual Occupation (Give kind of work done during most of working						6b. Kind of B	usiness/In	dustry		
Elementary/Seco	ondary (0-12)	College (1-4 or 5+	-)	iife. DO NOT use retired)							RIIT	LDIN	GS		
17. Father's Name (F	First Middle I	Last)			MAINTENANCE MAN BUILD 18. Mother's Name (First, Middle, Maider Surname)								EROB			
,		LIAN	PE	ERSAU												
19a. Informant's Na	me/Relations	hip (Type, Print)			19b. Maili	ng Address	Street a	ınd Numb	er or Rura	l Route Numb	er, Cı	ity or Town, S	state, Zip 0	Code)		
MARTHA	MARTI	NEZ/WIFE			3344	HEWI	TT A	VE.	#76 ,	5, SILVER SPRING, MD. 20906						
20a. Method of Disp	osition				ace of Dispo	· · · · · · · · · · · · · · · · · · ·					Date 20c. Location - City o					
1 ☐ Burial 2 ☐ 4 ☐ Donation		3 ☐ Removal from Specify)	1 State		AMBERS CREMATORY 12-31-2						RIVERDALE, MD.					
21. Signature of Fur	neral Service	Gensee EUNIVELL	M	M000)91 Ĉ	HAMBE 801 (d Addres RS F LEVE	s of Eacili UNER LAND	AL HO	OME & C	RE RD	MATORI	UM,P	.A. 737		
23a. Part 1. Enter the shock, or hear Immediate Cause (I	t failure. List o	r complications that only one cause on ea	ach line.		. Do not ent	er the mod	le of dying	g, such as	cardiac c	or respiratory a	rrest	,		Approximate Interval Between Onset and Death		
disease or condition resulting in death)		a. HE m	(or as a	CHA consequ	GIC ence of):	CERE	BRO	VASI	CULF	AR AC	C	DEN	T	S. Con and Board		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					ende offi											
that initiated events resulting in death) L		Due to	(or as a	consequ	ence of):											
		-														

Physician/Medical Examiner

Medical Certificate: To Be Completed by

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
IE EEMALE:

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

Director

Funeral

þ

Completed

Be

၀

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____

Month Day

23d. Date of delivery

24a. Was an

23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 X Unknown

Year

20850

ROCKVILLE

24b. Were autopsy findings available prior to completion of cause of

			_	performed?	death? 1 ☐ Yes 2 📈 No						
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 Yes 2 No	fospital: 1 XInpatient 2 □	☐ ER/Outpatient 3 ☐ I	DOA Other: 4 Nursing H	lome 5 ☐ Residence 6 ☐	Other (Specify)						
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)		injury work?								
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, street, factory)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								

	29a. Certifier	1 X Certifying Physic	cian: To the best of my knowledge, death occurr	ed at the time, date and place, and	d due to the d	cause(s) and manner as stated.
	(Check					and place, and due to the cause(s) and manner stated
	only one)	3 Certifying Nurse	Practitioner: To the best of my knowledge, death	occurred at the time, date and place	ce, and due to	the cause(s) and manner as stated.
ı	29b. Signature ar	nd title of certifier		29c License number		29d Date signed (Month Day Year)

Madar E., mo

D0067512

DECEMBER 28 2011

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANGALORE MD MADAN 9901 MEDICAL CENTER DRIVE

31. Date filed (Month, Day, Year) JAN 03

3. Registrar's Signat

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene per me,g924,02/15/2012dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death REGINA PRETTY MAN Physician/ 201 0945AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Memorial Easton Talbor 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 213-22-6661 Director 1 🗆 M 2 🗶 F 84 MAY 3, 1927 Usual Residence of Decedent MARYLAND 28a-f show death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD TALBOT ST. MICHAELS 1 Yes 2 No 10e. Street and Number 10f. Zip Code Funeral I 10g. Citizen of What Country? 107 MILES LANE, UNIT 115 21663 USA Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Rethyman 1 Yes 2 No Specify. Completed 3 X Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ELMER DAKIN CARRIE LOMAX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If it&m 27 is or other tra SALLY P. BERTICS, DAUGHTER 8231 NEW BRIDGE ROAD, DENTON, MD 21629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. WOODLAWN MEMORIAL PK. 12/29/2011 ☐ Donation 5 ☐ Other (Specify) EASTON, MARYLAND Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, F 200 SOUTH HARRISON STREET, EASTON, MD 21601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ INTRA CEREBRAL HEMORRHAGE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) CERTIFICATION APPROVED BY MEDICAL EXAMINER and burial-trar resulting in death) Last Due to (or as a consequence of): the attending physician ched for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No be detached for Month Day Pregnant at time of death Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes 2 X No Division of Vital Hospital or Attending Physician; funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 X Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. • Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural injury 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Giffifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the only one 29b. Signature and title of certifier 29c. License number Mus mu nu 0057108 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. MICHAELS IND 8005, TALBOT ST. 31. Date filed (Month De

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State Registrar Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		1	For State Registrar		Otato	OI IVIG	ryiaria	Cer	tificate	of De	eath		Re	g. No.	UII		
	Dharinia		1. Decedent's Na	me (First, Middle,	Last)	A	٠						ate of Death onth 12	Day 3	O Year	3. Time of 182	8 PM
	Physician Medic	al -	JAM In Encility Name	IES MER	give street and no	umber)	7211		4b. City, To	own, or Lo	ocation of Deat	h		4c. Cc	ounty of Deat	h	
	Examin	er '	univers	ITY OF A	MARYLAN	DME	DICA	LCEN	ER		BALTIN			<u> </u>	o Bir	hplace (State o	or Foreian
1	Funeral	4	5. Social Security 217–28–	Number	6. Sex 1 X M 2 □ F	7. Age	(In yrs. las	t birthday) Yrs.	II Official		If Under 24 Hrs Hours Min.	5-9	ate of Birth 0 0 0 0 0 0 0 0 0 0	Year)		MD	
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	yland -f shor ed at	ctor	10a. State	10b. County	.bot			Town or Lo								1 🗆 Ye	s 2 🛛 No
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	s 23a nust b	Funeral Director	8938 G	oldsboro			211 0:	12		601	nanic Origin? (S	Specify Y	es or No-		. Race - Ame	erican Indian,	
	r death or item niner n	by Fu	11. Marital Statu 1 Never N	s ∕larried 2. 🔀 Man	12. Was Do Armed	Forces?	ver in U.S. No	- 1	If Yes, specif		panic Origin? (S , Mexican, Puer	rto Rican	, etc.)	St	Black, Whit	e, etc. nite	
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pue	e filed ntal Hy ed oth event	To Be		ne (First, Middle, i		t					Anna Ma						
Maryland	and Mer s mark umatic			s Name/Relations	hip (Type, Print)			19b. Mai	ling Address	(Street a	nd Number or F	Rural Rou	ite Number	City or To	own, State, Z n MD 2	ip Code) 1601	
Ž,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 20a or 28a-f show important: If item 27 is marked other than "natural", or items 20a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.			ae Patch	ett (wi	fe)	20h P	lace of Disr	osition (Nam	ne of	ough Ne	Date	u E			or Town, State	
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Division of Vital Records, P.O. Box 68760	hat the ed by 1 detach	v Ph	Part II. Other	significant condi	tions contributing	g to death	but not re	sulting in th	e underlying	cause gi	ven in Part I.					to the cause Probably 4	
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Div	To the Hospital or Attending Physician; The law requires that the dewithin 24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.			1 0 0 4	ing Physician: To				ath occured	at the tim	e, date and pla	ace, and	due to the	ause(s) a	nd manner a	s stated.	d manner state
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			20. Nama sa	d address of pers	on who complete	ed cause o	f death (Ite	em 23a) (Ty	pe, Print)						,		
	7+10		DAW	N GOLUS	CRNP Z	-Z S	CUTT	1 GRE	ENE	STRE	ET, BA	ILT)	MORE	, MI) 212	U	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death Physician/ DECEMBER 29. LOUIS WILLIAM PARKER JR. 2011 9:12A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL 607 ADMIRAL DRIVE APT 203 ANNAPOLIS . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 **X** M 2 □ F 09/04/1946 MARYLAND Director 65 212-48-9499 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No FLORIDA SUMTER COUNTY THE VILLAGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2024 DORCHESTER AVENUE 32162 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Specify: WHITE 1 ☐ Yes 2 X No Specify: "natural", 3 ☐ Widowed 4 🏝 Divorced Completed Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 12 BUDGET ANALYST FINANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ LOUIS WILLIAM PARKER SR. ISABEL GENSLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health (tem 27 i JACQUELINE PARKER/DAUGHTER 1722 ABERDEEN CIRCLE CROFTON, MARYLAND 21114 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date DUEANEY CONTINUE Y Place)
MEMORIAL GARDENS 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/3/2012 TIMONIUM, MARYLAND 21. Signature Funeral Service Licensee 22. Name and Address of Facility LASTING HELFENBEIN & NEWNAM CRE 814 BESTGATE ROAD ANNAP TRIBUTES BY FELLOWS DLIS, MARYLAND 21401 TANNAPOLIS reart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician Ischemic Cardiomuopathy disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary · VISEASE if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events tran and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use conflibute to the cause of death? <u>Ş</u> hubertension Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2. autopsy performed? 1 Yes 2 X No , page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital Other: residence မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 X Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a To the Funeral C Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner. Of the basis of examination and a management of the basis of examination and the basis of examination and a management of the basis of examination and a management of the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examina 29c. License number Attending D 22861 12/29/11 Name and address of person who completed cause of death (Nem-23a) (Type, Print) . 10 NC Curay MD Suite 101 Bathmore, Marylana 21228 Haiden Choice Lane

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death $6:56P_{M}$ 2. Date of Death Leonard Calvert Phipps Physician/ Month December 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1404 Oak Bluff Road Edgewater If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 213-18-3798 Director 1 X M 2 □ F 04/22/1922 89 Usual Residence of Deced Maryland ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗶 No Maryland Anne Arundel Edgewater 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1404 Oak Bluff Road 21037 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify "natural", Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumaria. Elementary/Secondary (0-12) 12th College (1-4 or 5+) Electronic Technician U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leonard Calvert Phipps, Sr. Pauline Erby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Phipps / Daughter 517 Highland Drive, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/02/2012 Kalas Crematory Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Carlina disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-trar and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Month Day signed by the at Id be detached for 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has filled in by the funeral director, page 2 performed? 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\overline{D}\) Residence 6 \(\sum \) Other (Specify) م 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours to the Fune completely fi 2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 ED ゆえょうりろ 1-2-12 Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar

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gistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) - 31, Physician/ 2011 4:35 P M December Rafferty Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's 43991 California Hedgewood Lane Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗶 M 2 🗆 F Months Days Hours Min (Month, Day, Year) ay 15, 1922 Ireland 89 Director May 166-22-1603 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County Director 1 Yes 2 X No MD St. Mary's California 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 43991 Hedgewood Lane 20619 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No f Yes, Give 10/ Specify White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify: Year or Dates 1944-49 3

Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Television Production Engineer Television Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Rafferty Catherine Woods 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eileen C. Ligday/Daughter 43991 Hedgewood Lane, California, MD 20619 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 14, 1 E Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. Bonation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 2012 angnature of Juneral Service Littinger Francing Address Collins Funeral Home Inc. choud 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician <u> Atherosclerotic Cardiovascular Disease</u> 10 yrs disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Erner Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last as the burialcate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an **Hyperlipidemia** autopsy death? this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No within 24 hours after death.

To the Funeral Director. After this certific:

Completed filled in by the funeral director, the 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) မ D0031563 January 3, 2012

Registrar

20945 Great Mills Road #203 Lexington Park, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles M. Benner

JAN 04

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ : 40 am Gerald R. Rapson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Plata CIVISTA Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗙 M 2 🗆 F Dec 21. 1933 Months ${
m I1I}^{\scriptscriptstyle Country)}_{
m Ino}$ is Director 343-24-1760 78 Usual Residence of Decedent should Le filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location njury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Prince George's Temple Hills 1 🗌 Yes 2 💢 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 USA 3237 28th Parkway 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 XXMarried Navy ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: 3 Divorced 4 Divorced White Completed 1954 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Smith မ Dorothy Percy Rapson pern it. Page 1 and 2 should Le Dep: rtment of Health and Men Imp: rtant: If item 27 is marke any njury or other traumatie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3237 28th Parkway, Temple Hills, MD Gilda Rapson - Wife Date 27, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. Clinton, MD Resurrection Cemetery 2011 Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service 22. Name and Address of Facility Amanda M. 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day signed by the a d be detached for 9 Unknown P.O. Part II. Other significant conditions contrik ting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 12 Yes Completed 2 No 3 Probably 4 Unknown should 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 s autopsy performed? certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 200 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Phapatient 2 ER/Outpatient 3 DOA မ After this Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be the 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tid 29c. License number 201 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who c JRW H 31. Date filed (Month, Day, Year) 32. Registra Registrar

11-09738 Joseph Carlyle R	- N	Ple	ease Typ	e or P	rint in Bl Maryland	ack In	delible	Ink. E	nsur	e All Cop	ies Are Leg			4	
Joseph Carlyle N	i	1- For State Registrar			viaiyiaiiu			of Dear		u Mentai	Re	g. No.		1 43465	
Physicia Medical Examir	ın/	Decedent's Nam							·		2. Date of Death Month December	Day Year		Time of Death 1255 hrs	
()		4a. Facility Name (Joseph Car1y1e Ray a. Facility Name (if not institution, give street and number)							Location of De		4c. County of Death			
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Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/QD/Y) 406-48-3578 1 X M 2 F 77 Yrs. Months Days Hours Min. 4/19/1934											Foreign	ntry) KY	
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Maryland 28a-f show d at once.	Director	MD 10e. Street and Nu	Cecil mber		Colora 10f. Zip Code						10	g. Citizen of Wha			
r death with the Maryland or itens 23s or 28s-f sho must be notified at once.		1079 Fir	etower	Road					219	17		USA			
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ter dea	Fune	3 Widowed		1	Yes 2 s, Give Yaar	X No	1	Yes	2 X No	specify:		Specify:	Wh	ite	
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21.21 be fill Fried Fort, 9	æ	Joseph C									Little	hor City or Town	State	Zin Code)	
MD 21 d 2 should Ith and Mer n 27 is mar	٩	Francis				D.			•		, Colora			Zip Code)	
Ce, No. 1 and 2 Health Fitem ?	ı	20a. Method of Dis	sposition			20b. F	lace of Di	sposition (Na or other place	ame of ce	metery,	Date /2/2012	20c. Location -		own, State	
Baltimore, pernit. Pages l a Department of He Important: If ite		4 Donation			temoval from 5	iaio	Γ.Foa	rd Fur	neral	Home,	PA	Rising	Sur	n, MD	
Balt permit. Departu Importinjury	- [21. Signature of F	uneral Service	Licensee	10		1	22. Name an			R.T.Foard reet, Ris				
Physician	Н					d the death.	. Do not en	ter the mode	of dying	, such as cardia	ac or respiratory arr	est, shock, or hea	nt PID	Approximate Interval Between Onset and	
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tal Records, P.O. Box 68760, cian: The law requires that the death certificate be excertificate has been signed by the attending physician ector, page 2 should be detached for use as the burial.	Physician/Medic	23b. Was deceden past 12 month		he 1	Live birth	,	2	Fetal deat	h 3	Ectopic pre	gnancy	Month	Da	ay Year	
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S, P puires then signed and be d	ed by										_			opsy findings available	
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of Vital Records, ng Physician: The law requir the this certificate has been s meral director, page 2 should t		25. Was case refe	arred to medic	al I					26 Plac	e of Death (Che	1 Yes	2 No 1	✓ Yes	2 No	
Vital ysician this cert	o Be	examiner?	2 No	Hosp	ital: 1 Inpat	ient 2	ER/Outpa	atient 3	DOA	Other .		Residence 6	Other:	Scene	
1 of Vi ling Physi After this	J:IC	27. Manner of De			28a. Date of In (Month, Day Dec 27, 201	jury (Year)	28b. Tim 1230 hr	e of Injury	1 _	ury at Work?		how injury occurr er in auto au		sion	
Division tal or Attendir us after death.	catic	2 🗹 Accident	Inve	iding estigation	28e. Plece of					Yes 2 ✓ No building, etc.	28f. Location (Street and Number	er or Rur	el Route Number, City	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.		29a. Certifier 1		hysician:	To the best of	my knowled	lge, death	occurred at t	the time,	date and place,	and due to the cau ed at the time, date	se(s) and manner	as state	d.	
To th within To th compl	Medical	one) 2 🕎		and	the basis of ex	ammation a d.	and/or Inve			n, death occurr	ed at the time, date	29d. Date sign			
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Si Regis	tate trar		nun Llay, year	2012	/ /	rars Signat	A. A	back	_						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Tent gomer 5. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday, (Month, Day Y 1 🕱 M 2 🗆 F Days Hours Min. Director 578-20-9247 87 Nov. Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Medical Examiner must be notified at Funeral Director 1 X Yes 2 No Rockville Maryland Montgomery 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 14112 Arctic Avenue 20853 United States items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Dept. of the Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Vincent Rowe Antionette Rosanno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10601 Radstock Court, Damascus, Maryland 20872 Salvatore Rowe/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 1/3/2012 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. Silver Spring, MD. ature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to that contequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury -transit that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29/2011 841 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dena D. Robinson December 2011 6:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 20,1924 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Min 098-26-9974 Director 87 Utah Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 333 Russell Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2 Married "natural", or 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White 3 X Widowed 4 □ Divorced Specify. Completed Year or Dates. Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 Is marke any injury or other traumatic e Philip Arthur Dix Dena Whiteman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen D. Robinson/Son 1619 S. 91st Avenue, Omaha, NE 68124 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2011 Metropolitan Crem. Alexandria, VA 22. Name and Address of Facility 21. Signature of Juneral Service Licensee DeVol Funeral Home MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Parkinson's disease or condition Years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? lospital: Other: 2 🔀 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending or safter dec. eral Director: A* filled in by thr 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical 29a. Certifier within 24 hor To the Fune Completed fi Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D20148 December 29, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Dolinsky, MD, 911 Russell Avenue, Gaithersburg, MD 20877 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene RegistraMEND#23a(a/b)perMD1/10/12;BMW,MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:30 AM Physician/ Betty Stephens Riley December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Olne Montgomery thospital General Mentgomen If Under Social Securit Number 1 Year If Under 24 Hrs. (9) Birthplace (State or Foreign Country) Kentucky 7. Age (In vrs last birthday) **Funeral** 8. Date of Birth 1 □ M 2 🗓 F Months 82 406-36-5298 **Director** Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Sandy Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be Funeral 23a 17300 Quaker Lane, u.s.A. 20860 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked any injury or are. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ≥ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public School System Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Eeli Stephens Murtle Curnutte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17300 Quaker Lane. #D13. Sandy Spring, MD 20860 Edward L. Riley - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 又 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 01/05/2012 Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Physician. Medical resulting in death) Examiner Small Bowel Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Under or iinjury Due to (or as a consequence of) requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): -burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an the Hospital or Attending Physician: The law in thin 24 hours after death.

the Funeral Director. After this certificate has be the funeral director, page 2 signified filled in by the funeral director, page 2 signified in by the funeral director. autopsy 1 🗆 Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 XNo ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check vithin 2

To the I only one) 29d. Date signed (Month, Day, Year) 1)0071314

Registrar

State

30. Name and address of person

18101 Prince Philip Dr., Olney,

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 30 Zoli Physician/ 0150 obbins Carolyn Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Hospital Easton Memorial 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 12-21-1963 Maryland 219-82-9945 48 Director 1 🗆 M 2 🗙 F Usual Residence of Deceden 28a-f shov 10d. Inside City Limits 10a. State 10c. City. Town or Location ıral", or items 23a or 28a-f sho Examiner must be notified at Director Yes 2 No East New Market Dorchester Md. 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21631 USA 5840 Richardson Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: "natural", 3 Widowed 4 Divorced Black Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working If Hygiene. life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Food Line Worker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) : Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o and Mental I ျ Herbert Lee Briscoe Florence Gertrude Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21631 Sheena Chislom/Daughter 5840 Richardson Rd., East New Market, Md 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place). 20c. Location - City or Town, State Date Me Department of Important: If it any injury or o once. 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 01-09-12 Dover, Delaware Direct Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral 717 W.Division St., Dover, De. 19904 21. Signature of Funeral Service Licensee Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Breast Cancinema Ph sician/ ta 5+a disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) by the attending physician and stached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an has autonsy performed? this certificate 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 → Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending work?
1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1. Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier DO0 5311 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Dennis De 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25 AM 31 Medical 4a. Facility Name (if not institution, give street and numb 4c. County of Death **Examiner** Arundie Anne manoi Medi 8. Date of Birth (Month, Day, Ye Nov • 20, If Under 9. Birthplace (State or Foreign Sex Age (In yrs. last birthday **Funeral** Year) 1922 89 California **Director** 550-24-3223 or 28a-f show notified at 10d. Inside City Limits Oa. State 10b. County 10c. City, Town or Location Director Arnold Maryland Anne Arundel 1 Yes XXNo 10f. Zip Code 10g. Citizen of What Country? U.S.A. ō 10e. Street and Number ms 23a or must be n 21012 Funeral 1608 Comanche Road items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Examiner Armed Forces?

XX Yes 2 \(\square\) No Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates. WW II 1 Yes 2 No Specify: White "natural" Completed 3XXWidowed 4 ☐ Divorced the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. s marked other than " umatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Science Meteorologist Be 7. Father's Name *(First, Middle, Last)* Charles Leslie Roberts, Sr. 18. Mother's Name (First, Middle, Maiden Surname) ٩ Una Routson of Health and Menta fitem 27 is marked rother traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Arpold Marvland 21012 a. Informant's Name/Relationship (Type, Print) Mike Roberts/son 1608 Comanche Road Arnold, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important; If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Orchard Mesa Cemetery 1/6/2012 Grand Junction, Colorado 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Signature of Funeral Service License 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Hurokleron Onset and Death Immediate Cause (Final # ttysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions ir any, leading to immediate cause. Enter Underlying Line to for as a consequence of Exami Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Por in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown detached g Unknown s been signed by t should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 perform death? 1 Yes 2 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 2 🗆 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗹 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number & (04317 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 10× 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Twin Suite A. Amaphi, Diana NG 2007 Tidewater Colony Twin Suite A. Amaphi, 31. Date filed (Month, Day, 14 32. Registrar's Signature State Registrar

			Hegistrar						ne ne	ig. No.			
	nysicia Medic		1. Decedent's Name (First, Middle, Last) William Grat	ten Snod	dy				2. Date of Death Month Dec 24	Day Year	3. Time of Death 9:00 A M		
	xamin		4a. Facility Name (if not institution, give st	reet and number)			4b. City, Town, or	Location of Death		4c. County of Dea	th		
			197 B Court				Lotl	hian		Anne	Arundel		
	ineral		5. Social Security Number 6. Sex	INA O DE	e (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		rthplace (State or Foreign		
Dir	ector		Z17-44-0100 A	1M2UF (54	Yrs.			Month, Day, Aug. 2,	1947 Wa	ashington DC		
ъ	at w	١	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation				10d. Inside City Limits		
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s afte	eal",	륈	3 ☐ Widowed 4 XXDivorced	1 X Yes 2 If Yes, Give	140 1505	1	☐ Yes 2 XX No	Specify:		Specify:	White		
Iand 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene.	marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed	15. Decedent's Edu	cation	16	Sa. Deced	ent's Usual Occupa	ation		16b. Kind of Business	Industry		
in 72 e.	man " Mec	Ĕ	(Specify only highest grad Elementary/Seconday (0-12)	College (1-4 or 5	i+)	life. DC) NOT use retired)	luring most of work		Grocery De	eliverv		
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ore e 1 a t of H	or oth		20a. Method of Disposition 1√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√	lemoval from State	como	toni crom	sition (Name of atory or other plac	e), Dec.	30 I	20c. Location - City o			
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Baltimore, Maryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.	Important: If ite any injury or ot once.		21. Signature of Funeral Service License		, icin / i	- 1			ee Funer	al Home Ca	alvert, P.A.		
	- 60	\perp	Gary J Go							MD_20736			
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ath G	atter for u	iciai	in the past 12 months?	1 ☐ Live Birth 4 ☐ Pregnant a			Ectopic pregnanc Other (specify)	у		Month	Day Year		
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Division of Vital Records, lal or Attending Physician: The law requires after death.	recto	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc		farm, stre	et, factory, office		28f. Location (Str. City or Town,	(Street and Number or Rural Route Number,			
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JRN	11		30. Name and address of person who co	mpleted cause of d	13) P /	a) (Type, P	TAWAY R	D. LLIM	NTON , N	12/2 = 12	5		
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11-09616 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Eugene Mcthyre Smith 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 22, 2011 1622 hrs **Medical Examiner** Eugene McTyere Smith, III 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince Frederick Calvert Calvert Memorial Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** oreian Months Days Hours 59 Director 253-86-0273 Country) 07-08-1952 NC 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 X No s 23a or 28a-f show e notified at once. Lusby MD Calvert Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nett. If Health and Mental Hygiene.
nett. If Hean 27 is marked other than "natural", or items 23a or 28a-f sho re other trannatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20657 United States 1146 White Sands Drive 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 1 X Yes White f Yes, Give Year 1980–1988 1 Yes 2 X No specify: Specify: 3 Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Commerica1 Electrician 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eugene McTyere Smith, Jr. Avis Reeves Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Jean Smith - Wife 1146 White Sands Drive, Lusby, Maryland 20657 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 12/24/11 | Alexandria, Virginia 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service License Rausch Funeral Home, P. A. Lusby, Maryland 20657 P. O. Box 600, Approximate Interval disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Blunt Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial -23d. Date of deliven IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 Unknown Š pleted Records, 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Com 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Othera Nursing Home 5 Residence 6 Other 1 Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: of Vital Division

Dec 22, 2011 Natural 1 Yes 2 ✔ No Director: 5 Pending 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire Could not be Suicide or Town, State) Route 4 south of Ball Road, Saint Leonard, MD determined (Specify) Emergency Room Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME December 23, 2011 30. Name and address of person who completed cause of death (flem 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Russell Alexander MD 31. Date filed (Month, Day, Year) State

27. Manner of Death

1537 hrs

Driver motorcycle fixed object collision

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2011 9:22 A. M Claudia Ernest Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 800 Owings Calvert Marie Lane Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Country) Virginia 1 🕅 M 2 🗆 F Months Min Director 579-40-0423 84 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Calvert 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20736 800 Marie Lane 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates. 1945 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Police Officer, Detective Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest Claudia Mabel Lucille Compton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Marie Lane, Owings, MD Catherine Herchenroeder Daulghter 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Haught Family Cemetery 12-27-11 Rixevville, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. ren M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final THRIVE TO Physician FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner BEMENTIA Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' Director; After this certificate 2 🗌 No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, I 25. Was case referred to medica 26. Place of Death (Check only one) Be 2 No မှ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) N. Hendons D0060633 12/23/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

PRINCE

ROAD

Registra s Signature

HOSPITAL

110

31. Date filed (Month, Day, Year)

20678

MD

FREDERICK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LYDA MAE SWANDOL Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 1 🗆 M 2 💢 F vy Virginia **Director** 07/07/1934 234-48-3225 West. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 1 X Yes 2 □ No MD Allegany Cumberland ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be U.S.A. 400 Grand Avenue 21502 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iter Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. White Completed I Specify: "natural" 3 → Widowed 4 □ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland HOmemaker 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ျ Opal Virginia Pierce Roland George Showers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Swandol / Son 942 Weires Avenue, LaVale, MD21502 or other item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ott 1 E Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Restlawn Meml. Park 12/23/2011 LaVale, MD 22. Name and Address of Facility Upchurch Funeral Home, 21. Signature of Funeral Service Licerses 21502 202 Greene Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart indure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END STAGE disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to in neciste cause. Enter Underlying Examiner Due to or as a consultence of Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown detached P.O. is certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To Be Completed by 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral directors and the funeral directors. After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed au Robustiano J. Barrera,

Jr., M.D. - 200 Glenn Street, Cumberland, MD

21502

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ruth Agnes Stiver 10:10 AM December 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frostburg Village Nursing Home Cumberland Allegany 9. Birthplace (State or Foreign Country) Maryland Funeral 5. Social Security Number . Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs 8. Date of Birth Days 1 □ M 2 💢 F Months Hours (Month, Day, Year) 216-14-4364 90 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director MD Allegany Frostburg 1 X Yes 2 No 10e. Street and Number 10q. Citizen of What Country? Funeral 100 Honeysuckle Lane, Apt 207 21532 USA Hygiene. other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Retail ye 1 and 2 should be filed wit t of Health and Mental Hygier If item 27 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Lough Carson Wilmer Fitzwater Artie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12609 Henry Drive, LaVale, MD Wayne F. Belloff / Son injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 1 🔲 Burial 2 🔀 Cremation 3 🗔 Removal from State Cumberland Crematory 12/24/2011 Cumberland, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 Part 1. Emir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ commy uem Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed use as the burial-transi Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) been signed by the a should be detached 1 ☐ Yes 2 ☐ Unknown the ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has performed certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 1/ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1º Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 \square No Investigation Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) "i 721244

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

of Vital

Division

park

4 Broadway Street, Frostburg, MD

21532

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Registrar's Signature

Jesus H. Tan, M.D.,

31. Date filed (Month Day Year) DEC 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland /		artment of tificate of		d Mental H	/giene Reg. No. 4	2011	43476
	Physicia Medic	al	1. Decedent's Name (First, Middle Tom	Milton		Sta:	llings		2. Date of D Month Decemb	per 17		3. Time of Death 10:38 P M
-	Examir	er	4a. Facility Name (if not institution 1423 Dogwood 5. Social Security Number	Court	ie (In yrs. last b	oirthday)		or Location of Documental of D			g. Birth	egany
	Director		220–16–5742 Usual Residence of Decedent	1 🔀 M 2 □ F	85	Yrs,	Months Day	s Hours M		71926	Mary	land
	ne Maryland or 28a-f sho notified al	Funeral Director	MD A1 10e. Street and Number	legany	10c. City, To		erland			10g Citizo	n of What Cou	10d. Inside City Limits 1 Yes 2 No
	eath with t	Funeral	1423 Dogwoo	12, Was Decedent I	Ever in U.S.	13. V	2150	2 Hispanic Origin?	(Specify Yes or No		USA . Race - Ameri	
9800	ours after de tural", or it al Examine	by	1 Never Married 2 Ma 3 Widowed 4 Divorced	If Yes , Give Year or Dates.	WWII	1	☐ Yes 2 🔀 N	lo Specify:	uerto Rican, etc.)		Black, White,	
Maryland 21215-0036	within 72 ho giene. er than "na the Medic	Completed		nt's Education est grade completed) College (1-4 or 5		(Give k life. DC	ent's Usual Occi ind of work done O NOT use retire Ervisor	during most of	working		of Business Ir	
yland;	ild be filed v Mental Hyg larked othe atic event,	To Be	17. Father's Name (First, Middle, John	· ·	Stalli	ngs		18. Mother's Lavi	Name <i>(First, Middle</i> nia P∈	e, Maiden Su earl		lark
e, Mar	and 2 shou Health and tem 27 is m		19a. Informant's Name/Relations Susan L. Buch 20a. Method of Disposition		ter 2	252 F	-		Rural Route Numb t. Clairs Date	ville		3950
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 X Cremation 4 Donation 5 Other (21. Scripture of Funeral Service	Specify)	ceme	rland	atory or other pl d Cremat	ory 12	/19/2011	Cum	oerland	
8	e a <u>m</u> e e		23a. Part 1. Serter the disease, o shock, or heart failure. List	complications that caused only one cause on each line	d the death. Do				et, Cumbe		, MD 2	Approximate Interval Between
Mary Street	cate be executed Medical Examiner and the purial-transit the purial-transit the purial transit transit the purial transit	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if y leading to the cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to or as	a consequence	15/2	ailu	cano	ex			Onset and Death
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	~	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal dea		Ectopic pregna Other (specify)	ncy		23	d. Date of deliv	very Day Year
ds, P.O.	quires that the series of the signed by the details of the details of the details of the series of t	by	Part II. Other significant conditi	ons contributing to death b	out not resulting	g in the ur	nderlying cause	given in Part I.				he cause of death? bably 4 Unknown
Recor	The law recate has being page 2 sho	Completed							_ perf	s an opsy ormed? 2 No		ppsy findings available ompletion of cause of 2 \(\simega\) No
Division of Vital Records,	I or Attending Physician: The la after death. Director: After this certificate ha I in by the funeral director, page	To B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No 27. Manner of Death	Hospital: 1 Inpati 28a. Date of inju	ent 2 ER/C	Outpatien	10		ng Home 5 🗓 Res			v)
ision (• Attending er death. •ector: Afte by the fund	Certificate:	Natural 5 Pendi 2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	gation not be	ury - At home,	injury farm, stre	M 1 [rk? ☐ Yes 2 ☐ No	28f. Location	Street and N		l Route Number,
2	fospital or 4 hours aft and 1 hours aft constant bit is defined in	Medical C	29a. Certifier 1 X Certifying (Check 2 Medical I	Physician: To the best of examiner: On the basis of e	my knowledge	e, death o	ccured at the tim	ne, date and plac	e, and due to the c	wn, State) ause(s) and r	nanner as state	ed.
D	To the To the Comple		only one) 3 L Certifying 29b. Signature and title of certifie	Nurse Practioner: To the	best of my kno	wledge, d	29c. Licen	the time, date and se number 066150	d place, and due to t	he cause(s) as 29d. Date s	nd manner as si signed (Month, mber 19	tated. Day, Year)
(nds		30. Name and address of person Muhammad Nae 31. Date 1047/1001 Day New 1	eem, M.D., 6	25 Ken	t Av	enue, Cu	umberlan	d, Maryla	and 2	1502	
	Stat Registra	e ir	31. Date DEC 01, 99, 201	Denson-	a Goignature	arker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\Omega\) 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 27, 2011 Isabella L. Skidmore 07:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Allegany Frostburg Village Nursing Care Center Frostburg Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days 1 🗆 M 2 🗶 F March 25, 1922 217-14-4753 89 Maryland **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Maryland Midlothian Allegany 1 ☐ Yes 2 🗶 No 10e. Street and Number 11511 Blan Avon Road, S.W. 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be i Funeral 21543-U.S.A. death Was Deceder Armed Forces? Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked ot Ir other traumatic ever မ Isabella Stephenson Hugh Speir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21543-11511 Blan Avon Road, S.W. Midlothian Maryland Roberta Richards daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p tof F. 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Maryland December 30, 2011 Frostburg Frostburg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph_{_}sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of If any, leading to himselfa cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit certificate be executed Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director: page? Schould he detached for a in the past 12 months? Day Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗆 Yes Other 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 5 Pending 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) nos 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Month Physician/ NOEL SMITH ROBERT DECEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Thurmont 111 Locust Dr. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth **Funeral** Days Hours 1 XM 2 F Yrs. Director 83 MA 217-24-0210 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 ☐ No MD Frederick Thurmont 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 Locust Dr. 21788 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status rmed Forces?
Yes 2 \(\subseteq \text{No} \) Black, White, etc. ş 1 Never Married 2 A Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed 1951-54 traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " College (1-4 or 5+) Elementary/Seconday (0-12) engineer electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked o ပ Earl Smith Cecelia Migaucleas permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21788 Jennifer Hossain/daughter 111 Locust Dr., Thurmont. any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 01/04/2012 | Frederick, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between MOISSASachon ATherosclerone Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.0. page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by NTARIMI eumatoin Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physician: The within 24 hours after death. this certificate Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28a. Date of injury Certificate; 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) 1 Natural injury 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 003

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MD

160

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43479 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 29,2011 STOHLMAN MARY GROGAN 11:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** . Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 M 2 X F 83 Months Hours Min. May 25, 1928 579-48-9685 Washington D.C. Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland | Montgomery Rockville 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11400 Strand Drive #1 20852 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working filed within 72 ral Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) should be file and Mental F ပ Helen Tobin William Barry Grogan other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Clare S. Langley (Daughter) 4921 Shadywood Drive, Jefferson, MD 21755 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 21. Signature of Funeral Service Licer 22. Name and Address of Facility DeVol Funeral Home (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final disease or condition resulting in death) Once month Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence o burialattending physician for use as the buria Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Character at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year ed by the a 9 Unknown Division of Vital Records, P.O. s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by elastery injacction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy Ostisalh performed? Yes 2 To the Hospital or Attending Physician; The certificate 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗷 No Other: ည 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA After thi funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.
To the Funeral Director. All completed filled in by the fu s after death. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 1 Le beit Buschla ars, December 29, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 Russell KL. ROBERT SIRSCHDACH, MM Ald Gartherthing

State

Registrar

31. Date filed (Month, Day, Year)

03

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 31, 2011 Donald Charles Snyder 11:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Montgomery Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 200-16-6471 1 ፟፟ M 2 □ F **Director** 85 Jan. 8, 1926 PA Usual Residence of Dece or 28a-f show 0a. State 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3419 University Blvd. W, Apt. 102 20895 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. White þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: Year or Dates. WWII era Completed 3 ₩ Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " College (1-4 or 5+) Elementary/Secondary (0-12) Painting/Wallpaper 12 Contractor Be event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ George Snyder Anne Carey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sł Department of Health a Important: If item 27 is any injury or other tra 17 State Route 2023, Clifford Township, PA 18421 William J. Snyder/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 4, 1 🛣 Burial 🔑 🗌 Cremation 3 Gate of Heaven Cemetery 4 Donation 5 Other (Specify 2012 Silver Spring, MD f Fundal/Service I/cer 21. Signatu 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or resi iratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Intracerebral Hemorrhage Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 2 Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed been signal 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed' certificate 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other Speciful Hospital Other: 2 No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pendina Accident 12/25/11 1 Yes 2 X No unwitnessed fall out of bed Investigation unk 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3419 University Blvd determined building, etc. (Specify) home Kensington, MD 20895 Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu ည and title 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrah Miller CRNP

JAN 03 2012

31. Date filed (Month, Day, Year)

R143201

#100

1355 Piccard Drive, Rockville, MD 20850

12

31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William Drakeford \mathbf{p}^{M} 2:11 December 2011 31 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 24 Hrs. Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours (Month, Day, Year) 251-80-9196 **Director** 1**X** M 2 ∏ F 61 Yrs NC March 21, 1950 Usual Residence of Deceden 28a-f show 10a. State with the Maryland at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 No VA Alexandria 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral items 23a 1730 Preston Road 22302 IISA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11. Marital Status the Medical Examiner Black, White, etc Specify: White 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working 72 and Mental Hygiene. life. DO NOT use retired within 7 Elementary/Secondary (0-12) College (1-4 or 5+) Project Manager Real Estate Trust Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke, any injury or other traumatic e Jane Mulherin Robert Slay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francesca Slay/Daughter 6967 Cambridge Avenue, Cincinnati, OH 45227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date n. 2, 2012 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, Jan. Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA Francis Address Corlins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the dise shock, or heart failur se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events resulting in death). Let Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical Diabetes Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death ped 1 Yes 2 L 9 Unknown the signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 has certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 🗌 No 욘 1 Inpatient 2 XER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

15

DHMH 17 Rev 06-2011

Medical

29a. Certifier

only one 29b. Signature and title of certifie

3 🗆

31. Date filed (Month, Day, Year)

JAN 03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Sherk, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D67355

29d. Date signed (Month, Day, Year)

Dec. 31, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2:50a M Adeline Shapiro December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House Birthplace (State or Foreign Country) Social Security Numbe Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 117-18-5323 Director 1 M 2 X F 87 12/04/1924 New York Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County with the Maryland Director Bethesda 1 Yes 2 X No Maruland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 20817 U.S.A. 5 Darby Court permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. If Yes, Give White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Law Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Leon Axelrod Jean Shapiro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Darby Court, Bethesda, Maryland 20817 Mark Shapiro - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Judean Memorial Grdns 01/01/2012 onation 1 □ Other (Specify) e of Fundal SoliceVL ets. e Olney. Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Sign 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Das to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the burialphysician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Month Day Year 4 Pregnant a Pregnant at time of death 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pulmonary Hupertension 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypogammaglobulinemia page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 D Other (Specify) Hospice Hospital: ပ 1 🗌 Yes 2 🗶 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and fitle of certifier R143201

State

Registrar

6001 Muncaster Mill Road, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Debrah Miller

JAN 03

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 24, 2011 WILLIAM S. STAGG, JR. 6:15 P M Medical 4a, Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT EASTON WILLIAM HILL MANOR Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours Min 1/1/1922 1 V M 2 | F 89 Yrs NEW JERSEY **Director** 152-10-5555 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County aţ 10a. State 10c. City. Town or Location Director must be notified 1 🛣 Yes 2 □ No EASTON MD TALBOT 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 29270 CORBIN PARKWAY 21601 USA items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the GLASS BLOWER INDUSTRIAL GLASS 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည UNKNOWN WILLIAM S. STAGG, SR. 19a. Informant's Name/Relationship (Type, Print) (NEPHEW) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD P. VAN DER WENDE 101 WEEDON STREET, CENTREVILLE, MD item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o ō ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION: 12/29/2011 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, ERON 200 SOUTH HARRISON STREET, EASTON, MD MOHN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Unset and Peath Interval Between Immediate Cause (Final Physician/ UROSEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical law requires that the death certificate be Box 68760 the attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a d be detached f 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by BETES, ATHEROSCIEROTIC CARDIOUASCULAR 1 Yes 2 No 3 Probably 4 Unknown Records, Completed DEMENTIA, CHRONIL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy page INSMFFICIENCY cate 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital: Other: _ 2 🖈 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ neral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🙇 Natural work?
1 \sum Yes 2 \sum No injury 5 Pendina M Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

10+ VA

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifie

cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0053094

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RAYMOND SCHMIDT, JR. DECEMBER 2011 4:55 PM Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 27400 BULLENS CHANCE ROAD TRAPPE TALBOT 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

MARYLAND **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 **X** M 2 □ F Hours Months Days 1,1941 OCTOBER Director 70 Yrs 219-36-5493 Usual Residence of Decedent ıral", or items 23a or 28a-f show I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2X No MD TALBOT TRAPPE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 27400 BULLENS CHANCE ROAD 21673 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 X Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. WHITE "natural", Completed 3 Widowed 4 Divorced Specify: event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) IRON WORKER STRUCTURAL STEEL 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည RAYMOND SCHMIDT, SR. AUDREY COX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEONA C. SCHMIDT, WIFE 1 and 2 s f Health a item 27 i 27400 BULLENS CHANCE ROAD, TRAPPE, MD 21673 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or otf 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State WOODLAWN MEMORIAL PK. 1/3/2012 4 ☐ Donation 5 ☐ Other (Specify) EASTON, MARYLAND Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Circhosil Immediate Cause (Final Physician ah0/16 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of): death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit Due to (or as a consequence of): nding physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) be detached Unknown Hospital or Attending Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 🗌 Pending 1 Tes 2 🗌 No Accident Investigation Could not be 24 hours after deat Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State

Registrar

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JORGE H. ABREGO, MD

29 2011

31. Date filed (Month

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598 CYNWOOD DRIVE, EASTON, MD

12-27-11

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			For State	_							Mental Hy		201		43485
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) dead	Examir	er	4a. Facility Name (ii)	. 1 1	ve street and number)	atto	esylon	4b. City, To	wn, or Lo	cation of Dea	ath	40	c. County of D	leath lead	
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	arylan a-f sh fied a	Funeral Director	MD	Dorches	ator		ralsb								Yes 2 X No
	he Ma or 28k	Dire	10e. Street and Nu		ster	rede	eraisb	10f. Zip Ci	ode			10g, C	itizen of What		71
	with t	eral	5666 Fir	nchville	Rd			2	1632				USA		
21215-0036	and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f short from 27 is marked other than "natural", or items 23a or 28a-f short of the traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Mar 3 🏿 Widowed	ried 2 Married	12. Was Decedent Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates.	Ever in U.S. No		Vas Deceden f Yes, specify	Cuban, N	Mexican, Pue	Specify Yes or No rto Rican, etc.)	-	· ·	American Ind White, etc. White	·
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Baltimore,	permit. Page 1 Department of Important: If is any injury or c		21. Signative of Fu	inor Survice Lice	11/	10	CS IF	ellows	ddress o	1fenbe	in & New	mam	Funera	al Hon	ne, P.A.
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Box 68760	Attending Physician: The law requires that the death certificate be ar death. ector. After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the but	by Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 🔲 Fetal at time of de	death 3 [Ectopic pre Other (spec		_			23d. Date of Month	f delivery Day	Year
P.O.	hat th	y Ph	Part II. Other signi	ficant conditions	contributing to death	but not resu	ılting in the u	nderlying cau	se given	in Part I.	23e. Did	tobacco	use contribut	e to the cau	use of death?
S,	uires l n sign	ed b									. 10	Yes 2	2 🗐 No 3 🛭	Probably	4 🗌 Unknown
Örö	w req	Completed									24a. Was	s an opsy	24b. Were	autopsy fi	ndings available tion of cause of
Rec	The la ate ha page	you									per 1 \(\sum \) Yes	formed?	deat	h? Yes 2 🗌	
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Division of Vital Records,	r Attendii ter death. irector: A ire by the fu	Certificate:	3 Suicide 4 Homicide	Investigati 6 Could not determine	be 28e. Place of In	jury - At hor					28f. Location City or To			Rural Rout	te Number,
وَ	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier	Certifying Ph	nysician: To the best o	f my knowle	edge, death o	occurred at th	e time, d	ate and place	e, and due to the	cause(s)	and manner a	s stated.	
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	Nith with To t		29b. Signature and	title of certifier	1	-		29c. L	cense nu	umber			ate signed (M		Year)
			Heli	Il S	ou/ m	2		The	75	176	,	14	29/20	11	 _
	2		30. Name and addr		completed cause of	death (Item :	23a) (Type, F	rint)	P	5051	-n, mg	2	216	10	
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			State	Maryland /		rtment			Mental Hy	/ /		43487
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	lilicale	OI DE	alli	2. Date of De			3. Time of Death
-74	Physicia Medio	al	Eleanor Patricia Short						Decemb	er ¹i⁄7 2	0 [1]	9:05 P м
	Examin	er	4a. Facility Name (if not institution, give street and numb Somerford Assisted Living	*			wn, or Lo	cation of Death LS			y of Death .e Aru	ındel
-	Funeral		5. Social Security Number 6. Sex 7	Age (In yrs. last birt	hday)	If Under 1	Year 1	f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v Year)	9. Birth	place (State or Foreign
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	yland f shov ed at	ctor	10a. State 10b. County	10c. City, Tow	n or Loc	ation					1	Od. Inside City Limits
	or 28a-	Dire	Maryland Calvert	Owing	gs	10f. Zip Co	nde			10a. Citizen of	What Cour	1 Yes 2 X No
	with the s 23a c	Funeral Director	9705 Wild Fire Lane			2073				United		*
	r death		11. Marital Status 12. Was Decede Armed Force 1 Never Married 2 Married 1 Yes 2	∍s?	13. W	/as Deceden Yes, specify	t of Hispa Cuban, I	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ	
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Maryland 21215-0036	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)					8. Mother's Nam			ne)	
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1	Examiner	<u>*</u>	Sequentially list conditions, b.									
	ted Insit	min	cause. Enter Underlying Cause (Disease or injury	as a consequence (). 							
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00	ending use as	M/ne	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco	me of pregnancy th 2 Fetal death	3 🗆	Ectopic pred	ananov			23d. Da	ate of delive	ery
POX	e death the attu	Physician/M		nt at time of death		Other (speci				М	onth	Day Year
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	1	State Registrar	e (First Middle	e. Last)			Cer	tificate of	Death		2. Date of	Reg.	. No. 2 (348
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ral tor	2	Social Security No. 33-58-31 Usual Residence of	.95	6. Sex 1 X M 2 🗆		73 (In yrs. la	st birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of (Month, May 1	Birth Day, Yea 8,1 9	938	9. Bir Co Wes	thplace (Sountry) t Vir	tate or Forei
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Funeral Director	10	0e. Street and Nun 18809 D		Road				10f. Zip Code 2155	5			10g	. Citizen of	f What Co	ountry?	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e&f, Per FH &25 PER PHY G923 1/20/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2013 rancis November Medical 4a. Facility Name (if not institution, give street and number) Examiner Town 4c. County of Death baltimore Barbiew 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 220-66-0647 **Director** 1 **X** M 2 **D** F 56 Usual Residence of Deced March 16, 1955 Μđ 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 21222 ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r 6938 German Hill Rd. with Funeral 69:8 German Hill M. USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items. any injury or other traumatic event, the Medical Examiner mu once. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 yrs. Computers Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis B. Reinhardt Sr. Loretta McEvoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta Reinhardt mother 6938 German Hill Rd. Dundalk Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, · 28 2011 Nov Baltimore 4 Donation 75 Other (Specify) Bayview Crematory 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222 neral Servi 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final et and Death Physician/ Aspiration disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): CAED B. Cause (Disease or Injury that initiated events resulting in death) Last use as the burial-trar CATION APP been signed by the attending physician and Due to (or as a consequence of): Physician/Medical CERTIF Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal deat
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed lisorder 24b. Were autopsy findings available prior to completion of cause of death? Seizune 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 € Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: XX Yes 2 2 No မြ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 2012 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cindy Chai Johns HopkinsBayview Hospital Nu MO Baltimore, MD. 31. Date filed (Month, Day, Year) State JAN 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43490 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 Frederick Terman 28 2011 \mathbf{P}^{M} 8:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Siver Spring Montgomery If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Min. Director 222-09-7183 1 **X** M 2 □ F 94 08-29-1917 New York 28a-f shov items 23a or 28a-f sho her must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 XYes 2 No Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Grantchester Place 20877-3478 **United States** Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or ite Medical Examiner Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: "natural", Completed Specify: 3 ▼ Widowed 4 □ Divorced White Year or Dates. WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Building Manager Government other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental I ည Samuel Terman Kate Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen D. Terman - Son 12204 Meadow Creek Court., Potomac MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) injury or Department of Important: If any injury or 1-1-2012 Judean Mom. Gardens Olney Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ₽hymician/ disease or condition resulting in death) Multiple Myeloma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or Injury and that initiated events resulting in death) Last Due to (or as a consequence of): inding physician a use as the burial-Physician/Medical certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atter in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Day been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Dysphagia cate has i autopsv erforr death? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗆 Yes Other: ည 2 💢 No 1X Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

Registrar's Signature

NO

31. Date filed (Month, Day, Year)

JAN 03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D68096

Satyam Ashvinkumar Shah - MD. 1500 Forest Glen Road, Silver Spring Maryland 20910

01-01-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 18. TCHD, FH, pha 12/27 Certificate of Death Amend #11. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12-21-2011 Clara Ethel Thompson 9:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Caroline Denton 10961 Greenboro Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F 527-31-2347 1 1 1 9 1 1 9 5 5 Country) Director 56 Maryland Usual Residence of Decedent or 28a-f shov notified at filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD CAROLINE DENTON 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 10961 GREENSBORO ROAD 21629 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: er than "natural", the Medical Exa 3 Widowed 4 Divorced Specify WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Elementary/Seconday (0-12) 10 College (1-4 or 5+) CAREGIVER HOME-INSTEAD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ALBERT SNEAD permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic t EDITH RATCLIFF RATLIFF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JORDAN EWING, SON 230 MAIN STREET, P.O. BOX 524, PRESTON, MD 21655 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State JUNIOR ORDER CEMETERY 12/30/2011 4 ☐ Donation 5 ☐ Other (Specify) PRESTON, MARYLAND Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. RON 200 SOUTH HARRISON STREET, EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a nsequence of): **Examiner** ntially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 24 hours after deavin.

e Funeral Director; After this is a funeral director between the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending iniury work? 1 ☐ Yes 2 ☐ No Acciden
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Sp

DHMH 17 Rev 7/2009

State Registrar outh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43493 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ε. Taylor Emma December 2011 12:15P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center |Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F $\text{May}^{(Month,Day}14,1926$ Hours 577-38-5858 Mary Tand **Director** 85 Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗌 Yes 2 ሺ No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 USA 3421 Hazelwood Road Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. :ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Floral Designer Safeway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Franklin Dove Leona Maxwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Taylor/Daughter 3421 Hazelwood Road, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, akemont Mem'l Gardens 12/27/2011|Davidsonville. 21. Signature A Funeral Service Licer 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Unknown Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir -transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy **Hospital or Attending Physician:** The law requires that the death 24 hours after death. Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed **Director:** After this certificate has been siden by the funeral director, page 2 should. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 X Natural 5 Pendina Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 Homicide determined Funeral Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12/22/2011 D0017826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 4940 Eastern Avenue, Philip Smith, Baltimore, MD 21224

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

DEC 2 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Phyllis Ugoletti Medical 9:49 December 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 519 Shriver Avenue Cumberland Allegany . Age (In yrs. last birthday) If Under If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔽 Days Hours Min (Month, Day, Year) 03/02/1929 **Director** 82 220-26-9914 P<u>ennsylvania</u> Usual Residence of Decedent or 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 519 Shriver Avenue 21502 USA hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black. White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Co-Owner/Operator Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Louise Frank Bagatti Leonilda Flora Strini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shated Department of Health ar Important: If item 27 is JoAnn Moulden / Daughter 700 Winifred Road, Cumberland, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) any injury or Sunset Memorial Park 12/26/2011 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Brain disease or condition resulting in death) tumor 3 months Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has how admind hours. Cause (Disease or imjury that initiated events burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No signed by the atte Month Year Pregnant at time of death Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate ! performed Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No Hospital မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No Accident Investigation Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 2 | Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) · nonwekshi D0055325 December 22, 2011

Registrar

State

925 Bishop Walsh Road, Cumberland, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Wonsock Shin, M.D.,

DEC 22 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43495 1 - For State Registrar Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month WILSON MAZIE MYERS December 28,2011 1330 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 1 □ M 2**X** F 79 577-50-0668 Dec. 2, 1932 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director be notified 28a-f MD Rockville Montgomery 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country Completed by Funeral 23a must ! 20852 United States 1018 Grand Oak Way death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 'natural", or permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or 1 Never Married 2 X Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes. Give 3 Widowed 4 Divorced Year or Dates Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the 5+ DC Public Schools **Educator** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elsie Brown Joseph Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Wilson/Husband 1018 Grand Oak Way, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 01/04/2012 Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, alsberr 7400 Georgia Ave., N.W. Wash., D.C. 20012 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sensis Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) attending physician and for use as the burial-trapsit Cause (Disease or injury that initiated events Status Post Liver Transplant Due to (or as a consequence of): resulting in death) Last Physician/Medical Failure to Thrive Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) ☐ in the past 12 months? 1 ☐ Yes 2 🔣 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Hypothyroid 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A Accident Suicide the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D53691 December 29, 2011

Registrar
DHMH 17 Rev 06-2011

State

VIISON, Mazie

3/200 Tower Oaks Boulevard, Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

Atay Reddy, M.D.

31. Date filed (Month, Day, Year)

JAN 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER SAMUEL WALLACE 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Thomas More Nursing Home Hyattsville Prince Georges 5. Social Security Number 6. Sex 1 M 2 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Oct. 24, **Director** 548-38-3112 80 Usual Residence of Decedent than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4922 LaSalle Rd. 20782 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 [X Yes 2] N9 49—
19 49 19 52 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Completed Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Engineer Government injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important, If item 27 is Causton Toney - Guardian 606 Powhattan Pl NW Washington, DC 20010 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Quantico National Cem 1-17-2012 Triangle, VA. 21. Signature of Funeral Service Licensee Marsharlad Marchilly Funeral Home of Maryland Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician LN Samola disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exam that the death certificate be executed g physician and strans Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death signed by the a q Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗖 No Other: 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director, All completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Tyes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific

7:52 a M

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Year

Day

1 🗌 Yes 2 🔀 No

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2012

835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Beverly Gloria Watson December 28 10:40 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Gilcrist Hospice of Columbia If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours **Director** 1 🗆 M 2 🕱 F <u>578-78-9376</u> 52 March 15, 1959 DC r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2X No Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12161 Ell Lane, 20602 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Black, White, etc.
African þ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 Specify: American 1 Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Nurse's Aide Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cloria Lancaster Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12161 Ell Lane, #40, Waldorf, MD 20602 Troy Clegg / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) injury or Harmony Mem. Park 01/06/2012 Landover, MD 21. Signature of Functal Service Licensee 22 Name and Address of Facility Thibadeau Mortuary Service, p.a. M00956 Park Avenue, Gaithersburg, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Merke ears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): s the burial transit Cause (Disease or injury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? To the Funeral Director: After this certificate Popularies of the funeral director, page 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PICE ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar
DHMH 17 Rev 06-2011

CEPAR L

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUSEPH

31. Date filed (Month, Day, Year)

JAN 03

336

Registrar's Signature

D006 0634

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12-27-2011 Year Jeanne G. White 4:45 P M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Hospice of Queen Anne's Queen Anne's Centreville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Min. 1 M 2 X F 06^M2th - 2^N9²3 Director 087-16-3567 88 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10c, City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 Port Street Unit 206 21601 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker it. Page 1 and 2 should be filed witi rtment of Health and Mental Hygiei rtant: If item 27 is marked other i njury or other traumatic event, th Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Reilly Constance Egan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. White 9199 High Banks Drive Easton MD 21601 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other? Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Chesapeake Cremation: 1-4-2012 4 Donation 5 Other (Specify) Stevensville, MD 21. Signature of Funeral Service Licensee P.A. Pame and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison St. Easton MD 21601 JOHN R. MERLERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ozona ears Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death signed by the a 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 🖾 Other (Specify) Hospice 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Teal Dr. Sute 204 8221 31. Date filed (Mo Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

11-09613 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Michael Raphael Woodcheke 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day December 22, 2011 1447 hrs Medical Examiner Michael Raphael Woodcheke 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Months Davs Hours 12/14/1959 095-56-4423 52 Country) NY Director 1 M 2 F Yrs Usual Residence of Decedent 10d, Inside City Limits 10a. State 10c, City, Town or Location 10b. County FL1 Yes 2 No Pasco New Port Richey 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.

nett. If item 73 is marked other than "natural", or items 23a or 23a-f she rother tramantic event; the Medical Esaminer must be notified at once Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 11509 Pampas Drive 34654 USA 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funera 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married White 4 X Divorced If Yes, Give Year 1977-83 1 Yes 2 X No specify: Specify. 3 Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Construction Laborer 12 ltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis Joseph Woodcheke Mary Woodcheke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother 6122 Rock Hill Mill RD The Plains VA20198 Thomas Woodcheke 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Atlantic Crem 1 Burial 2 Cremation 3 Removal from State 1/4/2012 Glen Burnie MD 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD Lovna 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line **«Medical** Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Éxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, 27, per me, g923 1-25-12 sm **X** UNPENDED sician a Division of Vital Records, P.O. Box 68760, y the attending phys: hed for use as the bu 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by t i be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed ificate has been sir, page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 I DOA Other Nursing Home 5 Residence 6 Other: 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1___ Yes 2___ No Pending hours af er deat Director Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined within 24 hours a

To the Funeral I Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 23, 2011 O.C.M.E. and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Russell Alexander MD. 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 7:36 P M Month 201 Gene Austin Wilson December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Meritus Medical Center Hagerstown Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1X M 2 F Days 1 (Month 2 Day, / 1 9 4 4 215-42-3174 67 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 😾 Yes 2 🗌 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 333 Mill 21740 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö XXNever Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) line man clothing co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy Mae George B. Wilson Snurr injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 Coneflewer Dr., Williamsport, MD Department of Health an Important: If item 27 is any injury or any Betty Coddington (Sister) 20a. Method of Disposition cemetery, crematory or other place)
Smithsburg Crematcry 4/2012 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burlat 2 III Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg, MD Boardand Address of Farity ompson Funeral Home Wal 18 Middletown. MDNatt 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final Onset and Death Physician/ Medical LlyPoxia disease or condition resulting in death) Due to (or as a consequence of): Examiner ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury FEVER that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial SEPSIS Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav Pregnant at time of death the 9 Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FUNCTIONAL ASABILITY Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 2DM 24a. Was an the Hospital or Attending Physician: The law has page 2 performed Yes 2 DEMENTIA certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No ٩ Impatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After in propered filled in by the funer. Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) we n ARC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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